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An Address.[1]

By T. V. STUBBS BROWN,
President, Queensland Branch of the British Medical Association.

IN thanking the Council and members of the Queensland Branch of the British Medical Association for conferring on me the honour of the presidency for the ensuing year, I am fully conscious of the responsibilities which go with that office; and I can well understand the doubts in the mind of that German prince on the occasion of his accepting the invitation to one of the Balkan thrones, when he expressed to Bismarck his fears of the turbulent future, to which the Iron Chancellor grimly replied, "But whatever happens, it will always have been an interesting experience". And an interesting experience it has been to many of my predecessors, and not lacking its periods of unrest.

At our last annual meeting, our retiring President gave us a fully illustrated account of the development of medicine in Queensland, and coming very appropriately in the Jubilee year, it filled many gaps in our knowledge of local history. Tonight I wish to take up that torch and carry it into other fields, even at the risk of burning my fingers.

Authorities on education, visiting us from oversesa, have spoken repeatedly of the lack of consciousness of education in the public mind of Australia, where opinion is not yet sufficiently alive to modern trends and forces in this sphere. They have further pointed out that in England and the United States the secret of their progress has been the effort made to arouse the public mind, and to bring about a realization of the full meaning of education for individual and national welfare.

To us who know our public it comes as no surprise that its members remain aloof from one of the major social activities affecting the future of the people; but for the medical profession to do likewise would be a failure to discharge a debt we owe to the community and to our own earlier years of education.

We must agree with Albee, the veteran orthopædic surgeon of New York, when he says that "no profession can any longer remain secluded within its own walls . . . all are interlacing, closely related parts of the vast structure of society".

Meeting here tonight in this Great Hall of one of the oldest secondary schools in Queensland, I would urge that it is particularly fitting that as a profession we should give some thoughts to the earlier periods of education, and to some of the present day problems, even at the risk of ploughing in other men's fields.

In medicine we too have had our post-war difficulties and can with feeling share them; for nursing shortage can well parallel that of teachers, and in each sphere the problems of hospital and schoolroom accommodation run a similar course, showing graphs of the load of increasing numbers against the lag in buildings erected; and as the culmination of the difficulties in each case, the care of the aged and the upsurge of young Australians, both "old" and "new", will surely threaten the very basis of medical and educational efforts.

[1] Delivered at the annual meeting of the Queensland Branch of the British Medical Association on September 26, 1952.

These school difficulties include the recent raising of entry age, the increasing size of school classes and the problem of continuing the one-teacher country school; all of which stem from a common source—teacher shortage.

The Press has already given ample publicity to the failure rate in the earlier years of university courses; but as this matter is under investigation by the authorities concerned, it must be regarded as *sub judice* at this stage. But in all fairness it must be mentioned that this phenomenon is not peculiar to our own university. However, when unpleasant cracks appear in the upper part of a structure we naturally look to the foundations and the lower floors.

With most of us the years of our primary and secondary education are all too easily overshadowed by the later medical school and post-graduate studies, and we are apt to give only scant acknowledgement to these earlier periods of our development.

These school years for many of us are now "by distance made more sweet", and it is only by later personal experience that one realizes some of the possible defects. I, myself, would wish to have had far more English, and unhappily now I am in a position to know the full force of Barrie's remark of fifty years ago: "The man of science seems to be the only man who has something to say just now, and the only man who does not know how to say it."

In speaking of English, I refer not only to literature but to expression; the latter has now attained an important position, and is a subject in its own right at our university. This recognition could well be carried further in our secondary schools.

The quality of medical and scientific literature has earned its full share of criticism, and it was on good grounds that Quiller-Couch spoke of "men of science . . . making discoveries at a rate which left their skill in words outstripped". One feels sure, however, that this objection could not apply to many of the editorials of our leading medical journals, which can be rated as first-class literary efforts.

I have no wish to argue the value of the dead languages, but would make it clear that in the swing from humanistic to scientific studies history has suffered severely at the hands of the exponents of mathematics, physics and chemistry; the latest statistics available to me show that only 50% of girls and 30% of boys sat for history in the Junior Examination, while in the Senior only 10% of the boys and one-third of the girls sat for modern history, and considerably fewer for ancient history.

It is reasonable to question the wisdom of the trend which has resulted in such early specialization that we find it possible for a medical graduate to know more of the life history of some nematode than of the life story of mankind. On the other hand, those of us who were the victims of the old teaching have good reason to envy the children of today, for whom some effort is being made in primary and secondary schools to correlate and interweave literature, history and geography.

Happily, in history the detailed study of the dates of kings and queens and battles has given way to the broader understanding of social and economic forces in the different ages; while political and constitutional aspects have been relegated to a back place. And in geography a like fate has been shared by those appalling lists of rivers, capes and bays, which almost succeeded in destroying the innate attraction of the subject.

Putting aside the specific requirements of this or that entrance examination, we may take the broad view that any one subject has its value, either as a mind-trainer or as a foundation for later leisure interests. No one would doubt the role of Latin and mathematics in the first capacity, but except in rare cases they are unlikely to be of later use except for professional purposes. On the other hand, if only a few seeds of liking for English, history and geography survive to grow up in later years, there will be some hope of meeting the social problems arising from the increased leisure and the mode of using it, in some better way than the cinema, radio, television and pulp magazines. All of these could perhaps have been well delayed until we were mentally prepared to meet their onslaughts, with a population educated to use the leisure with discriminating and cultivated mind. These seeds of appreciation, as Chesterfield said of learning, "are like a tree which must be planted in one's youth, so that one may shelter in its shade in old age", and, unfortunately, as Compton Mackenzie recently said, "the whole trend of life at the present moment is against children reading".

Also today we have facing us the problem of absorbing into our community numbers of New Australian children, and for them the history of their new land and Australiana in general will, we hope, take the place of their old loyalties and traditions. In the United States this stage was passed years ago; and discussion with new Americans emphasizes the ardour with which they seized on the fresh history and literature as representing the background of their new way of life. History, moreover, is authentic tradition, for good or bad, and could well be a potent factor in overcoming the present spirit of taking for granted the good things of the comparative freedoms we now enjoy. Even some interest in the past, with its lessons of racial and national hardships, would impart a wish to look forward beyond the next election, or the next Cup, be it Melbourne, Doomben or Davis. I hope I will be forgiven for mutilating Kipling and asking "How can they know the present, who only the present know?".

The study of geography has received an impetus with the curtailing of distance by modern means of travel, and an added importance with the altering of our old European ideas concerning Pacific affairs; and there is little need to stress our position relating to South-East Asia. This subject, as taught in its modern form, provides a valuable link between the arts and the sciences, and it is pleasing to see that nearly 60% of the candidates for the Junior, and nearly 40% for the Senior Examination, sat for this paper.

A surprising feature shown by these examination statistics is that apart from physiology in the Junior Examination the sciences other than chemistry and physics receive almost no support. While chemistry and physics admittedly have considerable importance for later professional requirements, it is most debatable that they should be allowed to outshine so completely the biological sciences. For in the art of living we are not so much test-tubes and torques as higher organisms struggling against lower forms of life, our environment, each other and ourselves. It is deplorable that so many pupils leave school knowing so little of themselves and their biological background. This surely is prudery handed down from mid-Victorian times.

The developments in this State can well be approached by considering the background of conditions in England in the earlier part of the nineteenth century. For the bulk of the population a choice would be possible between a "common day school" and a school belonging to one of the two large societies, the National and the British. The common day school was self-supporting and very much a law to itself, the quality varied, and for the most part the teaching and accommodation were of a low order. In one school in Liverpool an investigating committe found a garret, ten feet by nine, holding "the master, one cock, two hens, forty children, and three black terriers". The report was not made public, and so there were no strong letters written to the London *Times* making vigorous protest on behalf of the dog-lovers of the nation.

The two societies demand more attention, as their methods of organized mass teaching continued for so many years. In spite of independent origins the systems had much in common. The Bell system, sponsored by the National Society for the Education of the Poor in the Principles of the Established Church, was devised in Madras by Dr. Andrew Bell, and later introduced into England as a means of giving cheap elementary education to the masses. These schools spread rapidly throughout the cities and towns, and came to be the village schools in most country centres.

For the most part, the teaching was carried out by the brighter pupils appointed monitors under the rather remote supervision of the master. With one monitor to every nine

or ten pupils, the instruction was of necessity very elementary and mechanical; but in this way large numbers were served at small cost. The "three R's" were taught, and throughout there was a strong church background. In contrast with the common day school, there was some order and discipline in spite of size. In one of these schools in Manchester no less than a thousand children were gathered in one room with only two masters and one mistress.

Of similar type were the nonconformist schools supported by the British and Foreign School Society, which sponsored the system of a Quaker, Joseph Lancaster; they used monitors also, but were non-sectarian and had a wider syllabus.

In spite of the last-mentioned society's smaller influence, there soon arose a most bitter rivalry based on the differences between the Established Church and nonconformists. The societies were at first supported by voluntary means; later each received an annual Government grant, but this served only to increase the ill feeling, so that competition became more important than their function of instructing children.

For many years any hope of major legislation designed to help education was postponed. Year after year the debate dragged on about methods of control and the distribution of finance to nonconformist bodies. These became major recurring political issues with successive governments, and may well have contributed to the fall of more than one.

It is little wonder then that R. H. Roe, on taking over in 1876 the headmastership of this very school, made the comment: "That traditions were lacking was not all disadvantage." And at the same time he noted that distinctions of wealth, poverty and religion were completely absent. Even at this stage, however, there was some attempt at organized teacher training; one society allowed a five-months term, while the other had a three-months course in which the stated object was "to keep them employed from five in the morning until nine or ten at night". From the remarks, one gathers that many of the trainees in this intensive course were unequal to the strain.

There were numerous small private boarding schools of varying quality; and although the pages of Dickens contain pictures of school life in caricature, there must have been good ground for many of his types, such as Squeers of Dotheboys Hall, who has an enduring place in the social history of that era.

This education compared most unfavourably with that of Prussia, Holland and Switzerland, where the State had undertaken the provision of education many years earlier, and Trevelyan points out that "the paternal rulers of Germany in the early nineteenth century educated their subjects, but gave them little political freedom and no share in government—the English State gave the common people some share in the government, but left them to be educated by private or religious charity".

However, the Government of the day was not altogether ignorant of the needs of the child worker, and various factory Acts required a school attendance of at least two hours daily, when a school was available, which was not often. Later the school period was increased to half a day. And to show that we are not thinking in terms of the dim past, I would remind you that only a year or two ago the death occurred of a senior member of the lay staff of our University who as a boy had worked his half day and then attended school.

Shortly after the separation of Queensland, Gladstone's *Education Act* marked the turning point in English education, which until then had lagged badly because of political timidity.

In this Act grants were given to all church schools irrespective of denomination, and many new schools were set up under the control of local boards.

The effects of this Act were considerable, and within twenty years the school attendance rose from one and a quarter to four and a half millions. And it is appropriate at this stage to quote Toynbee pointing out somewhat cynically that by this time the Yellow Press was already flourishing on a market provided by the increasing numbers of those able to read.

Provision for secondary education was made in the rising number of public schools, in the church schools, and in the grammar schools, which are worthy of a special mention in the history of English education. Their growth began in early Tudor times with endowments from the Church, and later the nobility, gentry and wealthy merchants supplied the means of founding and maintaining the local school. The number of schools increased to hundreds, until throughout England there was scarcely a town lacking its grammar school. This growth reached its height in the days of Elizabeth, when no less than 140 were established. The education of that era, when Englishmen first tasted to the full the wonders of their own language, is the hey-day of the grammar school, which provided the groundwork for that upsurge of learning which marked the close of the sixteenth century. Here, according to Trevelyan, "clever boys of the most varied classes of society received a good Latin education together, sharing the benches and the floggings", in marked contrast with the charity, village and public schools of the eighteenth and nineteenth centuries, when the classes were educated in rigid social distinction.

The gradual decline of grammar schools, in both numbers and influence, is an interesting subject in itself, and a commentary on the rising tide of class-consciousness in the eighteenth century, when public schools, academies and private schools, many under nonconformist control, took over secondary education. But for some strange reason in Australia, as the war historian C. E. W. Bean remarks, "we retained an Elizabethan robustness towards the Grammar school, quite free from the contempt with which the old Grammar schools, except the fashionable few, were coming to be looked on in England".

However, one of these grammar schools had increased in size to become a "Great School", and later a "Public School", and to Rugby in 1827 came Dr. Thomas Arnold, a man whose influence later extended to the borders of the Empire. The "Arnold tradition" was well founded by the time of his death in 1842, and several of his pupils had already reached Australia and were actively carrying on his ideas. Successive waves of headmasters and assistant masters over the next hundred years grafted many of them on to our secondary school system. The amount of "take" varied with the State, the time, and the schools, as it was confined at first to the corporate schools but is now carried on to the high schools.

The public school system in the eighteenth and nineteenth centuries maintained a very considerable degree of social segregation, no doubt justifying Trevelyan when he says: "Much of the success and much of the failure of modern England can be attributed to the Public Schools." The Gladstone Act, while making provision for primary education, gave little thought to secondary, so that by the close of the century, England was well behind many other countries in this respect: Switzerland, for example, was spending some eighteen to nineteen times as much as England per head of population.

Returning now to the Queensland scene, we find that the first census after the separation of the colony showed that some 60% of the children over the age of five years could not sign their own name, and that 40% were not attending any form of school. Such then was the problem facing the new Board of General Education.

Secondary education was given early attention, for in 1860 the Grammar Schools Act empowered the Government to allot £2000 to any municipality where £1000 had been raised by voluntary subscription; also a yearly subsidy of £500 was allotted, and this was later increased to £1000.

The citizens of Ipswich were the first to avail themselves of this offer; the foundations of the Ipswich Grammar School were laid in 1863, and the school was opened in 1864.

Such is the force of example that a subscription list was opened in that year in Brisbane; these efforts resulted in

the opening of the Brisbane Grammar School on February 1, 1869. It is interesting to note the name of the Honourable Charles Lilley, Q.C., among the trustees appointed by the Government.

In succeeding years other grammar schools were opened: the Brisbane Girls' Grammar School on Wickham Terrace in 1875, Toowoomba Grammar School in 1876, Maryborough and Rockhampton Grammar Schools in 1881, Townsville Grammar School in 1888, and the Rockhampton Girls' Grammar School in 1892.

The scholarship has become so much part of Queensland family life that its origins and early years are of interest. Under the *Education Act* of 1860, the Board of General Education was empowered to set aside a sum not greater than 5% of its funds for the purpose of granting exhibitions to grammar schools by competitive examination. There were as yet no grammar schools, and one would like to know the amount of funds available at that time.

Three of these exhibitions or scholarships were given to Ipswich Grammar School in its opening year, but by 1873 probably not more than 20 had been allotted. These early awards were apparently given on the direct representation of the trustees of one or other grammar school; however, in mid-1873, after correspondence with the trustees of Brisbane Grammar School, the Board decided to hold a competitive examination in Brisbane and Ipswich. Within a month of the Board's decision, the examination had been held, and the results published. Who will now speak of the slow pace of life in those days? Certainly there could have been no time for prolonged cramming.

Twelve of the 23 candidates from Brisbane were successful, and five of the 21 from Ipswich. And so this examination was launched on its long career.

It is worth reporting that the authorities were so considerate in those times that when a month later a lone candidate from Gympie belatedly heard of the examination, and applied to sit for it, he was allowed to do so. It is pleasing to learn that he was successful.

The stimulus of the examination was felt immediately in the primary schools, and provided an incentive which seems to have been most encouraging to pupils and teachers in the young colony. The system must have been well established by the time R. H. Roe became headmaster here, for he makes specific mention that "the system of State scholarships had already begun to supply that stream of good intellect and industrious habits, which has kept green the pastures of Queensland Grammar Schools ever since". One wonders today if the great-grandsons would merit that praise bestowed so amply on their forebears.

The number of scholarships awarded annually has varied. In the earlier years, some 60 to 120 were available, but the numbers awarded often fell short of these figures. In the '70's the Treasury advised the cessation of the awards, but fortunately this suggestion was not followed. In the depression years of the early '90's the number available was reduced to 36, but it was later increased by 50, and in 1913 the examination became non-competitive.

The number of candidates is of interest, and shows the rising tide of primary school attendance. In 1920 some 2400 sat for the examination and 1600 passed. It is expected that in December this year over 12,000 will sit, and on previous figures approximately 9000 will pass.

The scholarship examination has aroused considerable discussion, bringing out a wide variety of opinions, ranging from complete satisfaction on the one hand to a wish to abolish all examinations on the other. However, it can be stated that no truly satisfactory substitute for the external examination has yet been found; the internal examination has its supporters, but human frailty and the necessity for universal standards cast some doubts on this method. If the abolitionists can provide a like aim and incentive, one would be prepared to hear their claims further.

That the scholarship in Queensland has proved itself in the past is widely recognized; for example, C. E. W. Bean says that the system "made the chance of a first-rate education available to all clever children a generation before the other colonies did so", but this is not sufficient justification to continue in a self-satisfied attitude.

From personal questioning of teachers and pupils from other States, I find that they begin their secondary education at least a year earlier than we do; and in passing I would point out that the earlier scholarships were granted for three, and later for two and a half, years.

On medical grounds I question the advisability of subjecting some children to the stresses of an examination, with its inevitable drudgery and final mental strain, at a time of physiological transition; but if an examination must be held, could it not be at a younger age, thus allowing an earlier contact with the various subjects of the secondary school curriculum, and a more leisured treatment of them giving an opportunity for a wider range of interests for both examination and cultural purposes?

I am not suggesting that the height of the pyramid of education should be lowered, but am advocating as wide a base as possible within the limitations and abilities of each child.

There are many aspects of education in Queensland which deserve much more than the mere mention that I can give them. The great part played by church schools in this State, both in primary and secondary fields, must be acknowledged to the full. The Roman Catholic boys' secondary schools began with St. Joseph's College, Gregory Terrace, in 1875, and Nudgee College followed in 1891. Now no less than one-quarter of these schools in Australia are in Queensland. In earlier days the convent school in many country centres provided the only chance of some secondary education for girls.

The primary correspondence school and secondary and technical correspondence classes have been a great help and encouragement to many of our younger patients during a long illness and slow convalescence, as well as discharging their main function of reaching the isolated child in the country. Rural education is a problem to itself, and we are confronted with such difficulties as keeping open the one-teacher school and taking wider education to people in the country. Here one must give a word of appreciation for the Jubilee Art Train, now unfortunately disbanded. It was a first-rate idea and gave a wider outlook to many people who would otherwise not have the opportunity of seeing either pictures or books of such wide compass and high calibre.

In England and the United States it has been claimed that the systems of education are framed by townspeople for townspeople, and it has been further said that this has been one of the factors responsible for the shift from country to town. We in Queensland can ill afford to lay ourselves open to any such accusation. From the same sources comes the criticism that control of education in Australia is too centralized; but here in Queensland these remarks have been well met by the appointment since the war of four regional directors of education, who within their areas must be more conversant with local problems than a central executive in a distant city.

I would like to give a word of praise for the rise in musical interest and education in the schools, with a note of appreciation for the State String Quartette, now unhappily deceased. One would like to think of our having a State Conservatorium in the near future, so that it could do for music in the schools what the university has done for general education.

If we in Queensland are to confound the opinion expressed by Toynbee in almost medical language, that "our mass-produced intellectual pabulum lacks savour and vitamins", then we must hasten to further achievements. Already we run the risk of being left behind by the other States; in New South Wales alone five teachers' training colleges have been opened since the war, three in the country, and their annual teacher intake is in proportion much greater than our own. We are given to understand that staffing difficulties over the past ninety years have been recurrent, and that in lean times the numbers and quality of recruits to this profession have been lowered, to be followed by a glut. But merely to hope that the cycle

will soon again swing round surely savours of astrology, and offers as likely a solution as any which that nebulous science might supply.

Modern education, like modern medicine, is an expensive service to the community, and once we accept the need for these services then automatically we must carry the associated financial load; and to quote Bean once again, "whereas a Government could easily lose an election in the nineteenth century by spending money on education, it would be difficult to win one today without a vigorous education programme".

The forces of conflicting ideologies are abroad, and one envies the senior members of the community who can look back to the gracious days before August, 1914. However, we must take the world as we find it, and I will close with this quotation from Toynbee: "If the peoples' souls are to be saved, the only way is to raise the standard of mass education to a degree where its recipients will be rendered immune at any rate from the grosser forms of exploitation and propaganda."

Acknowledgements.

I wish to give grateful acknowledgement to Dr. C. E. W. Bean, and to Dr. L. D. Edwards, late Director-General of Education, Queensland.

THE UNITY OF KNOWLEDGE.[1]

By C. H. FITTS,

Melbourne.

A FEW years ago I was teaching some students in my wards on a Sunday morning. Most of them lived in a residential college where there is ample opportunity for mingling with students studying for law, arts, science, engineering and theology. The group of which I am speaking were above average intelligence, and subsequently nearly all did well in their final examinations.

We came during the round to a bed occupied by a young man, and the card above his bed gave his name as David Garrick Williams. I commented upon this and then turned to a student to ask what he knew of David Garrick. He was silent, and I asked another. I was then told that this was the name of a brand of cigarettes. A woman student said that it was the name of a film star, but her friend corrected her and said that it was the wrong Christian name. Another student recalled that there had been a Garrick theatre in Melbourne. Somewhat ashamed I turned to the patient for the correct answer. "Why", I asked, "did your parents give you the name David Garrick?" He said, "I was born on a Saturday night and that afternoon my father had been to the races and won a packet on a horse called David Garrick."

It is not so long ago in history that science and the arts and humanities shared the same language. In seventeenth-century England, Newton and Dryden, Pepys and Boyle were Fellows of the Royal Society. "The modern chemist is likely to be weak in zoology, weaker still in his general knowledge of Elizabethan drama, and completely ignorant of the principles of rhythm in English versification. It is probably safe to ignore his knowledge of ancient history." So wrote Whitehead in "Science and the Modern World". The chemist might well have made a similar comment about the modern historian's knowledge of chemistry. It does not matter which opinion is held, for what Whitehead is drawing attention to is the shattering of the unity of knowledge, and the rift in our culture.

A formidable array of evidence can be produced to show that unparalleled advances are being made through knowledge of the basic sciences, through laboratory investigation and through fragmentation of medicine into separate specialties. This necessitates a preparation that begins long before the medical course is entered upon, and the educational path is mapped out from the latter half of schooldays. In Melbourne we have only recently developed clinical research units in medicine, and we are only partially committed to the splitting of medicine into separate departments. I have no doubt that all this will come, and when we are possessed of everything that is already available abroad we shall have to ask ourselves if we are abreast of the times. Perhaps we need not wait, but we can ask ourselves if what is in existence abroad at this present time is sufficiently good to deserve our blind acceptance, or can we search, ourselves, for paths yet unexplored?

In New York in 1948 a member of the staff of the Rockefeller Foundation described our medical school as good 1912 standard, adding that he believed our good young men were as good as those in the United States when they were given the same opportunities. He pointed out that we were making no contributions to medicine. All of this was true, and not unkindly meant. For my own part I never felt the truth of it more than when I went to conferences, grand rounds, laboratories and special departments in the United States. Sometimes, however, I did rounds with the young resident medical officers and interns, and there I found my only comfort. Shorn of their laboratories and their investigations, and wrestling with the immediate problems of diagnosis, prognosis and treatment, they do not appear to any greater advantage than a similar group of our own men. If this is a fair statement, why do modern methods fail to produce a demonstrably higher standard than the so-called 1912 methods we have employed to give a medical service suited to the peculiar needs of this country?

I think that the imperfections of their system are not lost to the Americans, and in some places they pay at least lip service to the unity of medical knowledge by demanding that even the physiologist shall spend three months in the general medical wards. It is my impression that in the United States they are less committed to specialism than we or even the British are likely to become. Even so, what they are doing is not enough. I can illustrate what I mean by quoting a review of Professor Buchner's "Allgemeine Pathologie":

> In this work which took eight years to write great experience and wide philosophical culture have combined to produce a highly original presentation of pathology. It is in fact a synthesis of pathological knowledge obtained by all techniques, and is accordingly an important contribution to the teaching of the subject. The book is unique in its scope and comprehensiveness, and while the author lingers longest on what all pathologists will regard as common ground he takes the freedom of Plato to contemplate all time, and existence. Buchner holds that three great questions should dominate the thinking of a doctor, the nature of life, the nature of illness, and the nature of man. His work is not simply functional pathology; it is at once more profound and more imaginative; all branches of pathology, morphology, chemical pathology, abnormal physiology, and psychopathology are treated as sciences worthy of assiduous study for their own sakes. The distinctive character of this book derives from its author's sympathetic insight into a group of special disciplines, and his ability to integrate their achievements.

This quotation, I think, defines the qualities that should go hand in hand with science, and without which science is merely a method of limited understanding, a toolshop peopled by fitters and turners.

"Science has held aloof from this, and scientists have demanded a detached freedom to observe a world of objects. But the certainties of science are a delusion. They are hedged around with unexplored limitations, and the history of thought cannot be understood unless we take account of a grave weakness in the observational order. Observational discrimination is not dictated by the impartial facts. It selects and discards, and what it retains is rearranged in a subjective order of prominence. This order of prominence in observation is in fact a distortion of the facts. Thus we have to rescue the facts as they are from the facts as they appear. We have to

[1] Read at a conference of Carnegie Fellows in Medicine, Sydney, September 15, 1951.

rescue the facts in the discard and we have to discard the subjective order of prominence which is itself a fact of observation." What Whitehead is virtually saying is that the fundamental distinction that science draws between the comprehending subject and the object comprehended is false. The collapse of nineteenth-century dogmatism is a warning that the special sciences require that the imaginations of men be stored with imaginative possibilities as yet unutilized in the service of scientific explanation.

It has been said that in Gibbon's "Decline and Fall" there is not only the history of that phase of the Roman Empire, but also the history of eighteenth century thought and of Gibbon himself. It is not far-fetched to ponder on the history of the Hammersmith Postgraduate Centre or of the Mayo Clinic, or of the characteristics of the writers when one reads monographs from such places. Indeed, we should ponder on these things, for if it is true that scientific detachment is non-existent, the comprehending subject is an important part of the conclusions that he reaches about the comprehended object. I am not speaking now of rarefied abstractions beyond my comprehension but of the average paper that gains a place in a medical journal, for example, a contribution to therapeutics. All the conventional disciplines are imposed, and the paper proceeds to its logical conclusion, yet something is missing. I think it is the refusal to face the fact that the observer is personally involved. I call this awareness or insight. If I had to say off-hand who are the people in whose writings I have found this, they would not be many. It is present in the writings of Harvey, and I think Withering. Thomas Lewis had it, and among all the people who have written since Lewis on electrocardiography I would single out F. N. Wilson. I think that this awareness is singularly lacking in most of what has appeared in recent years on digitalis. With more insight and less detachment there would be less need for the multiplication of journals.

I have been saying that we are in danger of contributing less than our share to the balanced life if we do not make an effort to cherish the unity of knowledge. The good doctor at the zenith of his powers should strive for and command those qualities that the reviewer found in Buchner, a disciplined imagination, insight, originality, assiduity combined with great experience and wide philosophical culture, and a refusal to baulk at the immensity of the questions that confront any thinking doctor. The best brains in the profession are resigning themselves to a specialty, for to specialize is to limit, and sometimes to run the risks of pedantry, want of perspective, overemphasis of the unimportant and the passionate pursuit of small game which is not worth the efforts of the chase, described by Asquith in 1907.

This, I believe, is something we must give thought to in this country. Probably the life of a physician in consulting practice and with a hospital appointment at a teaching hospital is much the same in all the cities with medical schools in Australia. At the peak of his career such a person will be called upon to care for patients in his public hospital beds, to teach undergraduates and post-graduates at his hospital, sometimes to go to country centres to lecture; to take his share in the administrative affairs of the honorary staff, act as examiner and perhaps act on the faculty of medicine; finally he is at the services of his colleagues who wish to consult with him. In all this work he is virtually without skilled secretarial and clerical aid. There will be no time during the day and little at night for reflection, even if he had no other responsibilities in life. When is he to read the journals that, to be honest, he can never keep up with; how distinguish the fitters and turners from the Lewises and the Wilsons? When is he to ponder upon the nature of life, the nature of illness and the nature of man? No multiplication of conferences, no close but arid cooperation with a similar number of limited minds employed in the fields of radiology, hæmatology or even sometimes surgery, no group paper can entirely make up for something we have shut ourselves off from, not even the eruption of psychosomatic medicine or of that naïve American specialty, comprehensive medicine.

Whitehead gave as the books that influenced him in a general way in writing his three books "Science and the Modern World", "Process and Reality" and "Adventures in Ideas", Gibbon's "Decline and Fall", Newman's "Essay on the Development of Christian Doctrine", Sarpi's "History of the Council of Trent", H. O. Taylor's "The Mediæval Mind" and Leslie Stephen's "English Thought in the Eighteenth Century". He ventured then to commend to the notice of those interested in an earlier development of English thought and also in good literature the sermons of the Elizabethan and Jacobean divines. Perhaps my story of David Garrick has a little more to it than appears on the surface. If science itself was not too vast to send Whitehead searching into the byways of thought of Elizabethan divines, let us be careful before we shatter the unity of medical thought beyond repair.

We are committed to the basic scientific background, to clinical science, special departments and laboratory medicine, and must accept this as a fruitful and vigorous growth that has progressed further overseas than here. It would be foolish too to overlook the advances made in various specialties by devotion to a single task. Believing all this, we have yet more to seek, for I do not believe that medicine is so vast that it could not be better comprehended by the individual, nor do I believe that, on the average, devotion to scientific education produces the logical and disciplined mind, or the ability to think on a demonstrably higher plane than does the study of the humanities and the liberal arts. The story is told that Dr. James Conant, the President of Harvard, was attending a seminar at the University of Melbourne and a chemist said that if a youth proposed taking a science degree in chemistry it would be expected that he would begin the study of this subject before the age of fourteen years. Dr. Conant then confessed that they rather liked to get them at Harvard before they had done any chemistry at all. If we are to comprehend medicine as well as know a special department, we must have experienced other ways of thought as fruitful as our own. Our education must give us those things of which I have spoken, insight or knowledge of the whole—awareness of our own involvement and of the perilous material we have to deal with, and an attitude of mind that is not easily unbalanced. In this house are many mansions; in all of them should be audible the still sad music of humanity.

FURTHER NOTES ON THE DEEP CERVICAL FASCIA.

By E. S. MEYERS,

Faculty of Medicine, University of Queensland.

IN 1938 an article was published in THE MEDICAL JOURNAL OF AUSTRALIA on the arrangement of the deep cervical fascia (Meyers and Macpherson, 1938). Subsequently further articles appeared on this fascia in publications of the University of Queensland (Meyers, 1940; Meyers, 1950).

The present article appears with illustrations so that certain aspects of the arrangement will be made clearer, more particularly the continuity of the fascia.

Figure I shows the fascia in its full extent over the anterior and posterior triangles of the neck. The external jugular vein can be seen running obliquely across the sternomastoid muscle. Over the sternomastoid muscle the fascia forms the covering which is the sheath of this muscle on its anterior surface. Anterior to the sternomastoid muscle the fascia is fused with the fascia covering the suprahyoid and infrahyoid muscles. This layer of fascia which covers the sternomastoid is part of the first layer of the fascia of the neck—the so-called investing layer. Posterior to the sternomastoid muscle the fascia forms the roof of the posterior triangle.

In Figure II the fascia on the anterior surface of the sternomastoid muscle has been divided in the mid-line longitudinally and its edges have been turned back to expose the whole length of the muscle, which has been removed in its entirety. The fascia on the deep aspect of the muscle which forms the posterior portion of the sheath of the muscle has not been touched. There will thus be seen the continuity from the mid-line outwards of the fascia

FIGURE I.

over the suprahyoid and infrahyoid region, the fascia deep to the sternomastoid and the fascia which forms the roof of the posterior triangle. Deep to this fascia will be seen the internal jugular vein and the fascia covering the omo-

FIGURE II.

hyoid muscle. The upper and lower portions of this fascia are thickened, particularly that over and below the omohyoid, the latter being sometimes known as the omohyoid fascia.

In Figure III we see that the whole of the second layer of fascia has been dissected from the mid-line outwards and thrown backwards in one piece. Along the line of the internal jugular vein the fascia has been severed to free it from the fascia of the floor of the posterior triangle. From this cut edge also fascia winds itself round the internal jugular vein in its full extent to form portion of the carotid sheath. We now have exposed the fascia

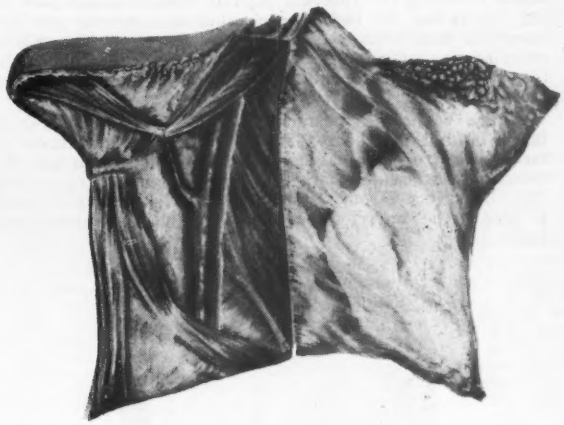

FIGURE III.

covering the anterior and posterior bellies of the digastric, the sternohyoid and the omohyoid muscles. In the posterior triangle may be seen the cords of the brachial plexus. Deep to these muscles may be seen the third layer of

FIGURE IV.

fascia. It covers from above downwards the mylohyoid muscle, the thyrohyoid and the sternothyroid muscles. This layer of fascia turns around medial to the carotid arteries and then forms the fascia covering the constrictor muscles.

In Figure IV is seen the fascia of the third layer in its full extent covering the mylohyoid, the thyrohyoid and the

sternothyroid muscles. It is a continuous layer running throughout the length of the head and neck, and laterally it turns round the posterior aspects of the constrictor muscles. It will be noted that the third layer of fascia runs medial to the common carotid external and internal carotid arteries throughout its entire length. With the fascia covering the internal jugular vein, it takes part in the formation of the carotid sheath. Portion of the mandible has been removed so as to show the fascia covering the superior constrictor. There is also shown in this picture the cut medial pterygoid and the styloglossus muscles.

Figure V shows a posterior view of this third layer of fascia, and it will be readily seen that the third layer of fascia is a true visceral layer ensheathing the larynx, the trachea, the œsophagus, the thyroid glands *et cetera*. This is a very strong layer, particularly posteriorly, and it forms the anterior boundary of the retropharyngeal space.

FIGURE V.

In Figure VI this picture shows the fascia forming the sheath of the thyroid gland well opened out. The thyrohyoid and sternothyroid muscles have been turned outwards. The superior thyroid artery and vein are entering the sheath of the gland to enter its upper pole. The fascia forming the sheath has been removed in part, and it is through the opening so formed that the ligature is passed round these vessels preparatory to dividing them to free the upper pole in the operation of thyroidectomy. In this picture the artery is shown in a superior position to that of the vein; in actual life it is whitish. Medial to the gland the cricothyroid muscle and trachea are seen, some of the fascia still remaining attached.

Figure VII shows a posterior view with the third layer of fascia. The inferior constrictor muscle comes into view and the thyroid gland is turned outwards from the trachea, the fascia intervening between the deep surface of this gland and the trachea being shown. This is only a weak layer of fascia, but should be left in the operation of thyroidectomy. The recurrent laryngeal nerve is seen deep to this fascia. Portion of the interior thyroid artery is seen. It pierces the capsule of the thyroid to supply the gland.

There is also seen in relation to these two structures the parathyroid gland. This gland was in a cul-de-sac of fascia, from which it was dissected free.

Of the parathyroid glands and the recurrent laryngeal nerve Hugh R. G. Poate (1940) makes the following statement:

> The parathyreoid, thymic remnants, external and inferior laryngeal nerves all lie outside this fascial envelope [which covers the thyroid gland], so that if

FIGURE VI.

this fascia is opened along the anterior border of the sterno-thyreoid muscle, it is possible not only in theory but in practice to shell the thyreoid gland out of its bed, without damage to other structures after division of the branches of the superior and inferior thyreoid arteries and veins, also the middle thyreoid vein, as they pierce the capsule to enter or leave the gland.

FIGURE VII.

In his description of total thyroidectomy Poate writes as follows:

> The upper pole is then lifted forwards, with a gauze swab the fascia is pushed back from its medial, posterior

and lateral aspects, and a watch is kept for the superior parathyreoid, which in 90% of cases can be pushed back with the fascial sheath . . . .

The fascia still being pushed away from the gland with a gauze swab, the lower pole is elevated and the veins are identified and clamped close to the gland. The inferior parathyreoids are deep to the fascial capsule and are seldom seen. The inferior laryngeal nerve always lies outside the fascial capsule and should seldom be seen.

The views of Lahey and Haggart (1935) are as follows:

As the result of a large experience (190) with the microscopically proved parathyroids at thyroid operations and on the specimen immediately after the operation with the specimen still sterile, we believe we can safely state that a parathyroid may be found at practically any position on, in, behind, or below the thyroid gland.

Lahey (1938) makes the following statement:

Up to the present it has been the custom for surgeons operating upon the thyroid gland to take the position that they do not want to see the recurrent laryngeal nerve, that if the nerve is seen it is endangered . . . .

About 3 years ago we instituted the policy of dissecting the recurrent laryngeal nerve in practically every type of thyroid operation . . . .

It is in this short course [between the horn of thyroid cartilage and the point where the nerve passes under or over the inferior thyroid artery] that the nerve is sometimes imbedded in thyroid tissue.

Acknowledgements.

I am indebted to Mr. B. Kynaston, Mr. R. Cross, Mr. I. Cary, Mr. D. Hogg, Mr. J. Breen and Mr. H. Smith, the student demonstrators of the surgical anatomy class, for the dissections illustrating the subject; and to Miss L. Pegus, of the medical school staff, who is responsible for the drawings.

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Poate, H. R. G. (1940), "Indications for, Technique of, and Results of, Total Thyreoidectomy", *The Australian and New Zealand Journal of Surgery*, Volume X, page 48.

Reviews.

CARDIAC EMERGENCIES AND HEART FAILURE.

"CARDIAC EMERGENCIES AND HEART FAILURE", by A. M. Master, M. Moser and H. L. Jaffe, being a small book, can cope with an important job, but cannot be expected to contain everything that everybody wishes.[1] However, Master and his colleagues have used their personal knowledge and experience to good advantage in the selection of the material to be included. They give a useful list of drugs *et cetera* to be carried in the emergency kit, and then discuss the various conditions which need treatment, especially stressing the importance of preventive therapy.

When one considers that a cardiac emergency is an urgent and vital matter, the value of this book can be appreciated. All the requisite measures for each condition are grouped together, the important ones being stressed and the others mentioned. It is not merely a recital of lists of drugs and procedures, but it also includes some clinical histories and is easily read. It abounds in practical tips which have been learnt by long experience.

A number of electrocardiograms are presented, either to illustrate some point in the diagnosis of the condition to be treated or to demonstrate the result of therapy.

This is a handy little book which will frequently be of most help when assistance is most urgently required.

[1] "Cardiac Emergencies and Heart Failure: Prevention and Treatment", by Arthur M. Master, M.D., Marvin Moser, M.D., and Harry L. Jaffe, M.D.; 1952. Philadelphia: Lea and Febiger. Sydney: Angus and Robertson, Limited. 8″ × 5¼″, pp. 160, with 13 illustrations. Price: 32s. 3d.

CLOT RETRACTION.

HÆMATOLOGISTS and clinical pathologists will find the reading of Budtz-Olsen's short book "Clot Retraction" enjoyable as well as profitable.[1] The author has provided a comprehensive review of the literature and has himself contributed to our knowledge of this much discussed but little understood phenomenon. Since the days of the phlebotomists the retraction of shed blood has provoked interest, and the numerous methods devised for its quantitative measurement are reviewed by Budtz-Olsen. A new and more accurate method has enabled the author to investigate the nature of the phenomenon and the significance of various modifying factors. In a series of ingenious and carefully planned experiments, details of which are included in an appendix, he has clearly demonstrated the primary importance of platelets, the inverse relationship between fibrinogen concentration and clot retraction, and the passive obstructive role of the red cells. Retraction is faster and more extensive with increasing temperature up to 42° C., necessitating rigid control of temperature in all experiments. The firmness of a formed clot is shown to be dependent, not on the presence of platelets, but on the occurrence or absence of fibrinolysis. The role in retraction of the various factors involved in blood coagulation has also been carefully assessed.

At the conclusion of his extensive laboratory and clinical investigations the author has suggested that clot retraction is probably a "phylogenetic relic of no importance" in mammalian life. This result must have been a disappointment, but the findings are presented with conciseness and lucidity. It is refreshing to read a book which so admirably clarifies a hæmatological mystery, and which justifies the exclusion of a long-established test from the laboratory investigation of clinical patients.

[1] "Clot Retraction", by O. E. Budtz-Olsen, M.D. (Cape Town); 1951. Oxford: Blackwell Scientific Publications. 8½″ × 6″, pp. 164, with 36 illustrations and 40 text figures. Price: 25s.

ARTHRODESIS.

H. A. BRITTAIN has published the second edition of his book, "Architectural Principles of Arthrodesis", ten years after the first which was published in 1942.[2] The first edition must be accepted as a preliminary report, for he has elaborated and redescribed his techniques after clinical trial; thus the second edition becomes a comprehensive monograph, almost rewritten, describing well thought out methods to fuse all the important joints by physiological as well as architectural grafting.

The book, clearly printed and set out, is well illustrated by coloured plates by Douglas Kidd, and each chapter is followed by X-ray pictures, including follow-up X-ray pictures from cases shown in the early book. His well-known, but in Australia infrequently practised, ischio-femoral arthrodesis is well described. He reports 80% of fusions, having used the method 154 times, mainly for tuberculous hips without any sciatic nerve injury. He has abandoned this method in the treatment of osteoarthritic hips for his V arthrodesis, in which he uses a long Smith-Petersen nail and an ischio-femoral tibial graft by blind technique. He avoids immobilization in a spica to save the knee from becoming stiff, and reports 42 operations with 36 fusions. Interestingly, he writes that when his arrow graft is used for fusion for flail shoulder following poliomyelitis, the joint should be opened, excised and fixed with a screw, as well as being

[2] "Architectural Principles in Arthrodesis", by H. A. Brittain, O.B.E., M.A., M.Ch., F.R.C.S., with a foreword by Harry Platt, M.D., M.S., F.R.C.S., F.A.C.S. (Hon.); Second Edition; 1952. Edinburgh and London: E. and S. Livingstone, Limited. 10″ × 7½″, pp. 208, with 257 illustrations, some in colour. Price: 42s.

buttressed across the axilla, to prevent the head from being levered out of the glenoid. For completeness, he has devoted an appendix to the history and technique of Naughton Dunn's triple arthrodesis.

Orthopædic surgeons would benefit by studying these carefully worked out methods of arthrodesis.

THE HUMAN PELVIS.

"THE HUMAN PELVIS", by Carl C. Francis, Assistant Professor of Anatomy at Western Reserve University, is apparently based on "A Course in Applied Anatomy for Surgical Residents and for Practising Surgeons".[1]

The anatomy of the pelvis is considered in ten chapters on systematic anatomy, and there are in addition one chapter on ossification and one on embryology. The chapter on ossification is a very good one, and the author acknowledges the work of Professor T. Wingate Todd, who was a leader in this field. The chapter on the articulation would be very much better if an account was given of the functional anatomy of these joints.

The author clarifies the action of the iliopsoas and confirms the opinion of Wright, who has pointed out that the iliopsoas does not function at all in either inward or outward rotation so long as there is no simultaneous attempt to flex the thigh.

The account of the connective tissues of the pelvis might have received a good deal more attention, and its importance as a support to the uterus might have received much more stress in a work on applied anatomy. There are some good pictures of the muscle and fascia from below, but one or two pictures from the superior aspect could be added with advantage.

At the end of each chapter there is an extensive bibliography including references to various gynæcological papers; but no mention is made of F. A. Maguire's book on the "Anatomy of the Female Pelvis".

GROUP TREATMENT IN PSYCHOTHERAPY.

"GROUP TREATMENT IN PSYCHOTHERAPY"[2] is a report of the experience of Robert G. Hinckley, a psychiatrist, and Lydia Hermann, a social worker, with this form of treatment in psychiatric cases. Their work was done in the Students' Mental Hygiene Clinic of the University of Minnesota, and so the experience relates to a selected group of the population. The authors consider that group therapy together with individual therapy has increased their therapeutic effectiveness. In discussing their experience they give many verbatim accounts of highlights from their group sessions to illustrate specific points. This excellent method makes the book more interesting and very easily read. Considerable attention is given to the role of the therapist in the group. The dominant type of therapist is criticized; the authors consider that a passive role is an ideal one. In their opinion, the authoritarian attitude arouses hostility and encourages dependence, but a kindly paternal role is needed at times to support the patient during stress; the function of the therapist is to guide and not to dominate the group. The role of the patient is not so clearly defined, but the authors consider that the support that the patient obtains from a group is derived by two mechanisms, namely, acceptance by the group and identification with it. Transference occurs also, but not to the same intensity as in individual therapy. Resistance, of course, is common. Resistances occur when anxiety is aroused and are often in the form of denials, phantasies, resentment and such mechanisms. Regression is often seen as a reversion to the level of the prior group sessions. Long silences also often occur. The authors consider that if the patients are tactfully handled the groups can be encouraged to progress. They make recommendation on the size of the group and its composition and give hints on the induction process. The relationship between individual treatment and group therapy is also discussed. This book contains much practical information for those interested in group psychotherapy.

[1] "The Human Pelvis", by Carl C. Francis, A.B., M.D.; 1952. St. Louis: The C. V. Mosby Company. Melbourne: W. Ramsay (Surgical) Proprietary, Limited. 9" × 6", pp. 210, with 61 illustrations, three in colour. Price: 52s. 6d.

[2] "Group Treatment in Psychotherapy: A Report of Experience", by Robert G. Hinckley, M.D., and Lydia Hermann, M.S.; 1951. Minneapolis: University of Minnesota Press. London: Geoffrey Cumberlege, Oxford University Press. 9¼" × 6½", pp. 146. Price: 31s. 6d.

Books Received.

[The mention of a book in this column does not imply that no review will appear in a subsequent issue.]

"Biologie d'Anopheles Gambiæ: Recherches en Afrique-Occidentale Française", by M. H. Holstein, Dr. ès Sc.; 1952. Geneva: World Health Organization. Monograph Series, No. 9. 9½" × 6½", pp. 176, with 22 illustrations. Price: 10s.

The author aims to make an exhaustive examination of those aspects of the biology of *Anopheles gambiæ* which are of interest in malaria control by insecticides, and to discover and establish the existence of anopheles races or varieties. The entire monograph is in French.

"Introduction to Dental Anatomy", by James Henderson Scott, B.Sc., M.D., L.D.S., and Norman Barrington Bray Symons, M.Sc., B.D.S.; 1952. Edinburgh and London: E. and S. Livingstone, Limited. 9" × 6", pp. 300, with 172 illustrations. Price: 35s.

The title is self-explanatory.

"The Principles of Line Illustration: With Emphasis on the Requirements of Biological and other Scientific Workers", by L. N. Staniland, A.R.C.S., D.I.C., A.R.W.A.; 1952. London: Burke Publishing Company, Limited. 8½" × 6", pp. 224, with 164 illustrations. Price: 25s.

This book is "essentially a text-book of drawing methods, first and foremost, though with a biological flavouring".

"What the General Practitioner Ought to Know About Human Actinomycosis", by V. Zachary Cope, M.S., F.R.C.S.; 1952. London: William Heinemann (Medical Books), Limited. 7½" × 5½", pp. 92, with 32 illustrations, a few in colour. Price: 12s. 6d.

The title is self-explanatory.

"Residential Speech Therapy", edited by C. Worster-Drought, M.A., M.D., F.R.C.P., F.C.S.T.; 1952. London: William Heinemann (Medical Books), Limited. 7½" × 5½", pp. 160, with 35 illustrations. Price: 15s.

A record of the work in speech therapy and education at Moor House School, a residential school of speech therapy.

"A Text-Book of Mental Deficiency (Amentia)", by A. F. Tredgold, M.D., F.R.C.P., F.R.S. (Ed.), assisted by R. F. Tredgold, M.A., M.D., D.P.M.; Eighth Edition; 1952 London: Baillière, Tindall and Cox. 9" × 6", pp. 562, with 48 illustrations. Price: 37s. 6d.

Considerably revised since the previous edition was published in 1947.

"Handbook of Gynæcological Diagnosis for Practitioners and Students", by Walter Neuweiler, M.D.; 1952. London: William Heinemann (Medical Books), Limited. 10" × 7", pp. 462, with 406 illustrations, a few in colour. Price: 80s.

Intended to supplement and not to replace text-books on gynæcology.

"The Range of Human Capacities", by David Wechsler, Ph.D.; Second Edition; 1952. Baltimore: The Williams and Wilkins Company. Sydney: Angus and Robertson, Limited. 9½" × 6½", pp. 200, with 13 text figures. Price: 43s.

A summary of knowledge of individual differences, especially that bearing on the limits and range of human capacities, with certain inferences from the data.

"Diseases of the Chest", by T. Royle Dawber, A.B., M.D., F.A.C.P., and Lloyd E. Hawes, A.B., M.D., D.A.B.R.; 1952. Baltimore: The Williams and Wilkins Company. Sydney: Angus and Robertson, Limited. 10¼" × 7", pp. 446, with 216 illustrations. Price: £5 7s. 6d.

The combined work of a clinician and a radiologist.

"A Handbook of Pædiatrics for Nurses in General Training", by Q. M. Jackson, S.R.N., with a foreword by Kenneth H. Talierman, M.C., M.A., M.D., F.R.C.P.; 1952. London: H. K. Lewis and Company, Limited. 7½" × 5", pp. 108. Price: 9s.

The book is intended to supplement text-books of general medicine for nurses.

The Medical Journal of Australia

SATURDAY, DECEMBER 27, 1952.

All articles submitted for publication in this journal should be typed with double or treble spacing. Carbon copies should not be sent. Authors are requested to avoid the use of abbreviations and not to underline either words or phrases.

References to articles and books should be carefully checked. In a reference the following information should be given without abbreviation: surname of author, initials of author, year, full title of article, name of journal without abbreviation, volume, number of first page of the article. If a reference is made to an abstract of a paper, the name of the original journal, together with that of the journal in which the abstract has appeared, should be given with full date in each instance.

Authors who are not accustomed to preparing drawings or photographic prints for reproduction are invited to seek the advice of the Editor.

THE MAN IN THE MARBLE.

ARISTOTLE had a notion, it is said, that marble contained a statue which would appear when the superfluous parts were chipped away. This, in figure, is a fine concept of education. Some twenty centuries after Aristotle, Addison wrote: "What sculpture is to a block of marble, education is to the soul", and Pope produced a couplet:

> Then take him to develop, if you can,
> And hew the block off, and get out the man.

Recently the same concept has been admirably restated and simplified by A. Morgan Jones,[1] who describes the germ of true education as "'leading out' from the student those qualities of mind and perception of which he is often himself unaware and in so doing developing his capacity for critical thought and judgment".

In every generation the cynics, the wits and the sages have sharpened their tongues on the subject of education, but none have got much further than this. Attempts at a precise definition of education are not particularly profitable, though compilers of dictionaries cannot escape them; the essence of the idea still lies in the Latin root *educare*, to draw out. Mere instruction in facts or indoctrination with ideas is not by itself education; though facts are important, and ideas are not to be despised because they are second-hand. Perhaps it is enough at present to suggest that education should teach a person to think and provide the foundation and building material for thought. In the education of the medical man the thought fostered must be broad enough to comprehend the whole nature of man. Medical education, as it is usually conceived, is perhaps narrower than this. No doubt those who frame the medical school curriculum, both pre-clinical and clinical, must address themselves to the matter in hand, and it is becoming harder every year to fit in what seems to be important. Our present concern, however, is with what lies outside the orthodox medical school curriculum, and particularly with pre-medical education. Not a little interest is being shown in this today, and it is surely a healthy sign that T. V. Stubbs Brown, in his presidential address to the Queensland Branch of the British Medical Association this year (see page 897), dwelt on the broader aspects of education. On the other hand it is sobering to read the remarks of C. H. Fitts in another paper in this journal (see page 901) in which he indicates the dangers of too narrow specialism and the stultifying influences at work in the present-day education of a doctor. Stubbs Brown quotes almost wistfully the remarks of Barrie and of Quiller-Couch on the inarticulate man of science, and he makes a plea for more attention in secondary schools to English expression. He might have gone further and given us Quiller-Couch's scathing condemnation of the misuse of our language by men of science, especially in the "monstrously invented words" with which they "bombast out our dictionaries", and all this because they are (and here "Q's" words bear the sharp barb of truth) "careless and contemptuous of a science in which they have no training". Quiller-Couch presents an unanswerable argument when he says that words are the only currency in which we can exchange thought even with ourselves. Accurate and good writing, apart from the years that it adds to the lives of medical editors, is important for the invaluable training it provides in clear thought, training which no man of science can despise or dismiss.

The plea, however, is for more than just better literary expression. It extends to the bigger field of "liberal education". This is discussed in the light of Newman's classical concepts in the paper by A. Morgan Jones to which we have already referred. Morgan Jones cannot quite accept the suggestion made by others that the medical course is wide enough to provide a liberal education in itself, and he tends to throw the matter back to the pre-medical phase of education. One comment, however, is most significant: "I do not for a moment suggest that a doctor is not fit to practise if he is not liberally educated, but only that he will be the better doctor if he is." In another place he writes of "the importance of laying a good deal of stress on the cultivation of the art of medicine, as well as the science". This we should surely heed. The development of a scientific approach to medicine in clinical practice as well as in the laboratory is wholly to be commended, but the peculiar glory of medicine is, in the words of the President of the American Surgical Association, Daniel C. Elkin,[1] "the ancient union of *art*—which we now more explicitly recognize as *humanity*—and *science*". Elkin points out the mistakes made by some medical schools and student advisers because "they thought medicine was a science only". This delicious phrase really gives us the conclusion of the whole matter. The virtues of a liberal education for any scientist are easily told, but a doctor is more than, though not other than, a scientist. He must weave the silver thread of science with the gold thread of humanity into the whole cloth of his ministry to man. This is his art. It is debatable how far he can achieve this if his pre-medical education has paid at most lip service

[1] *British Medical Journal*, August 30, 1952.

[1] *Annals of Surgery*, September, 1952.

to the humanities; but even if they are dispensable (which we question) they are certainly of value. Moreover, interest in them should not cease with leaving school or graduation. Lessons do not really have to lessen from day to day, despite what the Gryphon remarked to Alice. It is a matter for regret, if not alarm, when Fitts can tell us that a generation has arisen that knows not David Garrick, and that specialization in chemistry is expected to start at the age of fourteen years (it is a comfort to know that Dr. James Conant and Harvard do not feel the same way about it), when a doctor is ready to boast of reading nothing but medical literature, when Elkin can quote a distinguished professor of English as saying that "he no longer dared mention the Good Samaritan or the Prodigal Son without a thorough explanation as to who these characters were". Elkin has had much experience in the selection of American students for admission to a medical school and knows their outlook and what they have been taught to value. They expect admission committees to be impressed by the number of science courses taken, "which may even include vertebrate anatomy and a course in the rarer metals". He goes on:

If you switch the conversation to English literature and to history, you will find that the student has had a long course in history, in fact two quarters, and a comprehensive course, one quarter, in English literature from Chaucer to Ogden Nash. One whom I interviewed recently readily admitted he had never heard of Samuel Johnson, but said he knew all about Ben Jonson, whom he described as the great Negro heavyweight. He had been carefully "screened", whatever that is, had high grades in physics, and was admitted to medical school.

The attitude is one of substituting for the humanities "a bauble of practicality—not just the practical but what appears to be the immediately practical". This is not a happy state of affairs. Utility is important, extremely important, and often urgent, but it is not the only consideration, nor is it always the first consideration. The pure scientist and the research worker can be expected to support this sentiment, as they know only too well that growth of knowledge in their own fields is far from dependent on the pursuit of the useful. But the implications go much further; in Sir Richard Livingstone's words (quoted by Elkin):

Human progress depends on a double advance—increase in knowledge and the discovery of higher values. We concentrate mainly on the first, but the second is far more important. Increase of knowledge may lead to nothing but elaborate barbarism; as indeed our own age shows. . . . The ultimate importance of any nation is estimated not by its conquests, commerce or comfort, but by the values which it has brought into the world and the degree to which they are embodied in its life.

To the particular field of education of the medical man this has a particular relevance. We quote Elkin again:

If a physician has a diminished insight into himself, it is reflected in an equally diminished insight into the problems of his patients, and there remains undeveloped in him that aspect of the profession which is the means by which its scientific knowledge is translated into benefit for the patient. He should concern himself with the problems of man and society, but he cannot do this if his thinking and awareness do not go beyond the confines of a single field of endeavor. In spite of so large a part played by the fate of the dice (and Luck is not always a Lady), by and large, personality and character, and the education which helps to mould them, will out.

However small this subject of science concentration versus a broader study of the humanities may seem in the whole scheme of education, Elkin states, its implications are not small. "Is not the study of the humanities a means of enlarging the life experience? What is its worth if it does not offer a perception of the role of mankind as revealed in its history, its wisdom, its beauty, its ugliness, its growth, its regressions—in brief, its life? What is its worth if it is not a catalyst in the perception of the truth that 'shall make ye free'? If this *be* its worth, it is worth much!"

If these things impress us, we will want to do something about them. A good deal can be done. Those who have any say in the matter can help to discourage too early specialization in the schools and to modify matriculation requirements or attitudes and standards in first year medicine that make such specialization imperative. Teachers at all stages of the medical course can encourage a "liberal" and cultivated outlook. Medical students are said to have too much essential work to do to find time for anything else. This is only partly true, and they can be encouraged to discriminate in what they do and read in their leisure time. The graduate needs the same discrimination. Mark Twain has said that "cauliflower is nothing but cabbage with a college education"; but sure it is the fine flower of the humanities joined to science that transforms the *chou* into the *chouffeur*. This is something that we may all pursue. For those who teach and influence their colleagues as well as medical students there is a special duty. It is the sculptor's task to find and free the man in the marble.

Current Comment.

THE LOCALIZATION OF THE ANTI-ANÆMIC FACTOR IN THE STOMACH.

LOOKING back on the remarkable and almost fortuitous discovery of the remedy for pernicious anæmia, we are struck by the contrast between the evolvement of this simple therapeutic method and the obscurities concerned with its rationale. It was perhaps a simple transition from the use of liver substance to that of stomach, but we might reasonably have expected that research would soon reveal the location of the active factor. The hypothesis of Castle has been amply supported, but there are still perplexities. One authority who has done much to discover which tissues in the stomach possess anti-anæmic activity is Meulengracht, but he has also presented us with some unsolved problems. He has recently returned to this subject, and has produced some interesting results.[1] In the early days the search for the intrinsic factor was not conclusive, but Meulengracht and others showed that pure preparations could be made from various areas of the pig's stomach, and therapeutic tests established that the anti-anæmic factor was confined to the pyloric glands and was absent from the secretory glands of the fundus. This work was carried out on the pig's stomach, as above noted, and this fact must be stressed, for on the top of this work came the surprising discovery that in the human stomach the anti-anæmic factor was present in the fundus, and that histological examination could demonstrate no morbid atrophic lesions in the pyloric glands. Then the work of Fox and Castle in 1942 showed that the active factor in the human stomach was found in a different anatomical site from that in the pig's stomach, a finding which, as Meulengracht has pointed out, appears to be at variance with the principles of comparative physiology. Meanwhile, other workers had tried the effect of whole mucosa and whole muscularis, and it seemed from these experiments that both elements were needed to produce remission.

[1] *Acta medica Scandinavica*, Volume CXLIII, Fasciculus III, 1952.

Meulengracht, in summarizing this and similar work, remarked that the techniques of these workers varied, and he has now performed a fresh set of experiments with pig's stomach. In these he has used the muscularis and the mucosa after careful separation. The female workers in the laboratory suggested a simple technique of dissection, by using the thumbs covered with sacking as in skinning eels. This method was not only simple, but proved to be reliable; microscopic examination of the defatted and pulverized product showed that small glandular elements could be found in the muscularis powder, though in the main the preparation consisted of pure muscle fibre. Similarly, the mucosal powder also contained shreds of muscle. Experiments were carried out with these fractions on patients with untreated pernicious anæmia, and it was found that both muscularis and pyloric mucosa produced full therapeutic effect, that is, remission. That the muscular fraction was active was surprising. Meulengracht wonders if this could possibly be due to diffusion of an active substance from the mucosa to the muscularis during the time when the stomachs were lying rinsed and packed in ice, a period lasting up to twenty hours. Was the material used in reality a mixture of intrinsic and extrinsic factors? The findings are apparently contradictory, and since the work was done only on the stomach of the pig, nothing can be said of the observations previously made on the human stomach. The author can offer no explanation of the observations made by himself and others. The riddle he propounded some years ago has not yet been solved, but surely there is adequate stimulus to induce researchers to pursue the topic.

SURGICAL MEASURES TO INDUCE GROWTH OF BONE.

RESEARCH on puppies has shown that some increase in the length of the hind extremities has followed the creation of an arterio-venous fistula in the external iliac vessels. The interest in this work lies in the hope that some such method might be used to promote the growth of bone in children who had suffered a damaging attack of poliomyelitis. Joseph M. Janes and Earl C. Elkins have now made a report of the results they have obtained by the deliberate use of this method.[1] Janes and Musgrove have already reported their experimental studies on this subject, but until December, 1950, it does not appear that any surgeons attempted to perform a vascular procedure with the object of stimulating the growth of bone. There are, of course, good reasons for hesitating to produce an artificial arterio-venous fistula between important blood vessels. As war surgery has shown, the traumatic production of such a lesion in a limb is usually followed by progressive cardiac failure, since the heart is working with a considerable constant extra load. Further, the actual increase in length of the long bones in experimental animals was not great, and in one instance at least no increase was noted; indeed, the treated limb became slightly shorter. Against this must be set the optimistic thought that the observed cases of arterio-venous fistula are usually in adults, and are often associated with aneurysm. With these reservations in mind Janes and Elkins explained the procedure and its unknown hazards to the parents of a girl of six who had had poliomyelitis, and whose left leg was some 3·6 centimetres shorter than the right. An arterio-venous fistula was produced between the left femoral artery and vein in the mid thigh. This was done simply by isolating and clamping the vessels and, after tying and cutting any branches at the site, making an incision of one-half inch in each vessel followed by a simple side-to-side anastomosis, the area being bathed with heparin meanwhile. A strip of "Gelfoam" was placed over the incision. No complications occurred, and a similar operation was performed on five other patients at the clinic. Careful review has not shown any evidence of cardiac embarrassment to date, and the children are leading normal lives. The first patient nine months after the operation has reduced the disparity in the length of the limbs by 0·6 centimetre. The authors promise to report their cases in detail. As yet they wisely hesitate to express any opinion on what result may be expected, and how long the fistula should be allowed to persist. They further quote the history of a traumatic case, in which there was evidence of a rapidly built-up collateral circulation, which persisted after ligation had been performed. This is really a physiological experiment, but it will be watched with interest, in order to answer the question: "Is it worth while?"

[1] *Proceedings of the Staff Meetings of the Mayo Clinic*, August 13, 1952.

SEBORRHŒIC DERMATITIS AND PYRIDOXINE.

IN 1934 György described a vitamin essential for the maintenance of muco-cutaneous surfaces in the rat. Animals fed on a diet deficient in this substance developed a scaly skin and tail and swollen red paws. The condition resembled, in some respects, seborrhœic dermatitis in man. The vitamin was later isolated and is now known as pyridoxine. The vitamin seems to be essential for all animals including man, and much is now known of its action in the body. The relation to seborrhœic dermatitis is, however, not clear. Some workers claimed moderate success in the treatment of this condition in man by the oral administration of large doses of pyridoxine. Most, however, had little or no success. Deprivation studies in man failed to produce significant dermatitis. On the other hand the administration of the antipyridoxine analogue desoxypyridoxine, in cases of lymphoma, produced, in the majority of patients, oily, scaly, erythematous seborrhœa-like lesions of various parts of the body.

A. W. Schreiner, W. Slinger, V. R. Hawkins and R. W. Vilter studied two patients who had signs of pyridoxine deficiency induced by a diet low in vitamins of the *B* complex and 100 milligrammes of desoxypyridoxine per day.[1] These patients developed severe seborrhœic-like dermatitis in symmetrical areas. While the diet and the desoxypyridoxine were continued, pyridoxine, in water-soluble ointment base, vanibase, was applied to a small area of one side of the face in a concentration of 10 milligrammes per gramme of base. The plain ointment base was applied to symmetrically located areas. The areas treated with pyridoxine ointment, but not the control areas, cleared completely in forty-eight hours. Application of desoxypyridoxine ointment to mild seborrhœic lesions in another patient caused considerable intensification of the lesions.

As a result of these observations twenty-three patients with spontaneous seborrhœic dermatitis of the sicca type of the scalp, brow and other parts were studied. Eleven patients were given 300 milligrammes of pyridoxine by mouth daily for a month. Two showed slight improvement, the rest were unchanged or became worse. Parenteral administration had very little effect. Twelve patients treated with local applications of pyridoxine ointment had complete clearing of the areas treated in five to twenty-one days. As long as the application was continued the lesions remained quiescent. In most cases the lesions returned at varying periods after local therapy was discontinued. Other types of seborrhœa, particularly the moist erythematous, secondarily infected type, were aggravated by the ointment or not affected. It is suggested that in patients with natural seborrhœic dermatitis there is a disturbance of pyridoxine metabolism in the skin due to one or several of the following: first, an increased requirement for pyridoxine in the skin, perhaps because of a local disorder in fat metabolism; second, an increase in the destruction of pyridoxine in the skin; third, an increase in the "barrier" to pyridoxine between bloodstream and skin.

[1] *The Journal of Laboratory and Clinical Medicine*, July, 1952.

Abstracts from Medical Literature.

DERMATOLOGY.

Exfoliative Dermatitis and Cortisone.

B. M. WEST (*Archives of Dermatology and Syphilology*, January, 1952) states that three patients, all of whom had been treated unsuccessfully with the usually prescribed medications, were successfully treated with intramuscular injections of cortisone. The average dosage was 100 milligrammes given three times on the first day, twice on the following three days and once on the fifth day; 50 milligrammes were given on the sixth and seventh days and 25 milligrammes on the eighth, ninth and tenth days. The period of administration of cortisone varied from one to five weeks. No toxic effects were noticed; recovery from the dermatitis was dramatic.

Keloid following Patch Test.

J. E. DALTON (*Archives of Dermatology and Syphilology*, January, 1952) states that accidental cuts, scratches or puncture wounds, surgical incisions and vaccination needling are regarded as the injuries which most commonly initiate keloids. However, spontaneous keloid formation occurs as a result of continued irritation or persistent infection in a certain location. It is more likely to occur in persons with dark skin, but it also happens with less frequency in persons with light colouring, as in the author's case. Clinicians who have watched patients with keloid tendency note that this tissue reaction to injuries will not develop consistently. Marshall and Rosenthal advanced the theory that there must be intense tissue œdema with increased circulating fibrin in the background of this type of lesion. The author considers that in an intense patch reaction such as occurred in his patient, it is conceivable that there were both epidermal and dermal injury and intense tissue swelling.

Sulphoxone ("Diasone") Sodium for Dermatitis Herpetiformis.

T. CORNBLEET (*Archives of Dermatology and Syphilology*, December, 1951) reports the results of treatment of *dermatitis herpetiformis* with "Diasone" (sulphoxone sodium). He states that the commonest side effect of the drug is transient normocytic anæmia. Closely correlated with it may appear asthenia, mental depression, moderate dyspnœa on exertion, headache and dizziness. These are not indications for withdrawal of the drug unless the effects become excessive. Withdrawal is indicated by depression of the white cell count below 5000 per cubic millimetre. The usual beginning dose for adults is one 0·3 gramme tablet each day. If during the first week no symptoms of intolerance appear, the dose may be increased to two 0·3 gramme tablets daily. This dosage is continued for two or three weeks. If no symptoms of intolerance develop, the dose may be increased to three 0·3 gramme tablets daily and continued at this rate if no severe side effects develop. Almost all the patients had decided improvement or complete remissions with three tablets a day. All required at least two for improvement. The longest time any of the patients remained on sulphoxone therapy was two and a half years. The drug is not a cure; when the patient with *dermatitis herpetiformis* stops taking sulphoxone he has a relapse in several days. Most of the author's patients had been refractory or had shown a poor response to other drugs including sulphapyridine.

Treatment of Superficial Dermatomycoses with Asterol.

H. G. RAVITS (*The Journal of the American Medical Association*, March 22, 1952) presents an evaluation of the clinical use of asterol dihydrochloride (2-dimethylamino-6-[beta-diethylaminoethoxyl]-benzothiazole dihydrochloride) in the treatment of different types of superficial fungous infections of the skin. The drug was used in three different forms: (*a*) as a 5% ointment in a polyethylene glycol ("Carbowax") base; (*b*) as a 5% dusting powder; (*c*) as a tincture containing 70% alcohol. (Stritzler *et alii* by patch tests demonstrated that in 2% and 5% concentrations asterol is not a primary irritant, but that it is so in a 10% concentration.) The clinical types of fungus treated in 100 cases were as follows: (*a*) *tinea pedis*, caused by *Trichophyton gypseum*, *T. purpureum* and *Candida albicans*; (*b*) *tinea cruris*, caused by *Epidermophyton inguinale*, *C. albicans* and *T. gypseum*; (*c*) *tinea corporis*, caused by *Microsporum lanosum* and *Epidermophyton inguinale*; (*d*) *tinea capitis*, caused by *M. audouini* and *M. lanosum*; (*e*) *tinea versicolor*, caused by *Malassezia furfur*; (*f*) *onychomycosis*, caused by *T. gypseum*, *T. purpureum* and *C. albicans*; (*g*) paronychia, caused by *C. albicans*; (*h*) *pruritus ani*, caused by *C. albicans*; (*i*) *thrush*, caused by *C. albicans*. Culture material was taken from all patients prior to therapy. The scrapings were planted in modified Sabouraud's agar and grown at room temperature. Cultures were not obtained in all cases. All patients were treated on an out-patient basis with instructions for the proper application of the medication. Patients with *tinea pedis* comprised the largest group of the series. The predominating species of fungus was *T. gypseum*. Of 54 patients treated in this group, 29 had been resistant to treatment with other fungicides, including the fatty acid compounds. Some patients used asterol dihydrochloride powder in the morning and 5% asterol dihydrochloride ointment at night. Others used the ointment twice daily and a few used the tincture and ointment alternately. The duration of treatment for the entire group ranged from one week to two months. In 24 cases the condition healed completely; in 24 it was strikingly relieved, and in six it failed to respond. The most dramatic results were obtained in patients with chronic infections of five to seven years' standing. They had been treated previously with many different fungicides, including fatty acid preparations.

Pustular Miliaria.

W. C. LOBITZ, SENIOR (*The Journal of the American Medical Association*, March 29, 1952), states that a particular type of inflammatory reaction that is easily confused with folliculitis can develop in the sweat gland and duct. Such a lesion is not the result of bacterial infection *per se*, but is another manifestation of sweat retention phenomenon. Pustular miliaria is seen most commonly in the summer season when the weather is hot enough to produce sweating, or in any season if an occupation, activity or state of health induces sweating, or if sweating is caused by emotional stimuli. It is more common in adults than in children. The eruption is always preceded by some other skin damage which has produced injury, destruction or blocking to the sweat duct or its orifice. The author has seen it associated with contact dermatitis (acute and chronic), urticaria, localized neurodermatitis, intertrigo of obesity, and *lichen planus*. Not uncommonly it is seen several weeks after the patient has discontinued treatment on account of relief of an inflammatory dermatosis. Pruritus is always present, with exacerbations of the pustular miliaria. Most commonly the pustules will be found on the flexor surfaces and folds of the extremities, in the groin, in the intergluteal cleft, and on the scrotum; however, the pustules can be distributed in any area of skin that has been previously inflamed, and they will always be found only in these previously inflamed areas.

Treatment of Atopic Dermatitis with Cortisone.

T. H. STERNBERG AND J. H. LINDEN (*The Journal of the American Medical Association*, March 15, 1952), in order to avoid diagnostic confusion, state that they consider atopic dermatitis to be the dermatological component of the eczema-asthma-hay fever complex. Their clinical material consisted of 24 adults with chronic severe atopic dermatitis. Three general methods of administration of cortisone were evaluated—intramuscular, oral and topical. An individual daily dose of 200 to 300 milligrammes administered either orally or intramuscularly produced the best results. This dose was continued until maximum benefit was obtained. The medication was then discontinued by one of the following methods: (i) complete and sudden discontinuance; (ii) gradual reduction of daily dose; (iii) increase in time intervals between doses; (iv) administration of a terminal course of corticotropin; (v) substitution of orally administered pregnenolone acetate for cortisone. During the administration of cortisone all patients were given diets of low salt content, and five grains (0·32 gramme) of potassium chloride were administered three times daily. A daily dose of 200 to 300 milligrammes of cortisone produced a dramatic improvement in all but one of the patients. Clinical improvement reached its maximum in nine to eighteen days. By this time the skin appeared normal in all areas except those in which cutaneous involvement was of long standing—namely, the flexural areas of the extremities. Here a moderate degree of lichenification generally persisted. All patients in whom cortisone therapy was abruptly terminated began to relapse twenty-four to thirty-six hours after the final dose. The patients also relapsed with the other methods of discontinuing administration of the drug. Intramuscular administration was the most effective. Remissions could be maintained with continuous cortisone therapy. Other effects of

cortisone were euphoria and diaphoresis in all patients, moon facies in two, pigmentation in two, and acneiform eruption in four. The authors believe that the use of cortisone in the treatment of atopic dermatitis should be confined to severe cases in which all conventional modalities have failed to arrest progress of the disease. In these cases the course of therapy should be limited to four to six weeks. They believe cortisone to be contraindicated in the treatment of mild to moderate atopic dermatitis.

UROLOGY.

Acute Renal Insufficiency.

R. A. KELLEY AND L. D. HILL (*The Journal of Urology*, November, 1951) discuss the nature of the clinical condition commonly called "uræmia" and the role of potassium in this intoxication, and draw special attention to treatment by intestinal lavage. They state that by modern definition, renal insufficiency denotes the failure of the kidneys to maintain the chemical equilibrium of various substances within the plasma and other fluid compartments of the body. Water and electrolyte imbalance is one of the most important factors in the production of this clinical state. The retention of urea and other nitrogenous products is easily reduced by lavage of the upper part of the small intestine, but most emphasis is placed on the control of potentially dangerous elevations of serum potassium content in acute uræmic states. Serum potassium levels above 7·5 milliequivalents may lead to potassium intoxication, and sometimes to the characteristic sudden death that occurs in acute uræmia. The signs and symptoms of hyperpotassæmia are bradycardia, dyspnœa, respiratory paralysis, coma and cardiac standstill. This study, conducted on dogs as well as in clinical human cases, demonstrates the ease of removing potassium from the blood plasma by lavage of the upper part of the small intestine. This is far simpler than the use of dializing membranes (artificial kidney) and other recently reported methods, such as peritoneal lavage and cross transfusion. A Miller-Abbott tube is passed to a point about five feet past the pylorus. A Levine tube is then inserted through the other nostril down into the stomach. The perfusate solution enters the Levine tube at a rapid rate controlled by a Murphy drip apparatus. It is aspirated through the distal end of the Miller-Abbott tube with suction by a Wangensteen apparatus. The composition of the perfusate solution is sodium chloride six grammes per litre, sodium bicarbonate three grammes per litre, calcium gluconate one gramme per litre, glucose 20 grammes per litre; tap water is used, as there is no need for sterility.

Uretero-Sigmoid Anastomosis.

J. J. CORDONNIER AND W. J. LAGE (*The Journal of Urology*, October, 1951) publish an evaluation of the early and late results of mucosa-to-mucosa, end-to-side ureteric implantation into the sigmoid colon. They state that in 54 cases there was no operative mortality. Fifteen patients were operated on from two to two and a half years ago, and of these eight are still alive and comparatively well. Urinary sepsis was present in nearly one-half of all cases, but in only two was this a very serious complication. Intestinal gas was present in about 10% of cases. In about one-sixth of the cases there was intestinal reflux up the ureter. The results, as judged by excretion urography, compare favourably with those of other methods. The late development of acidosis is a real problem, but can be well controlled if recognized. Molar lactate solution given intravenously, and sodium bicarbonate given by mouth, frequent emptying of the bowel by the patient (two-hourly) and limitation of salt intake are the most useful measures. It is possible that the incidence of sepsis and acidosis can be reduced in future if a permanent colostomy is established just proximal to the sites of anastomosis, an artificial bladder being thus formed from the rectum. This was done recently on one patient, and up to date the findings of his chemical studies have remained satisfactory. It remains to be seen if the improvement is sufficient to warrant the inconvenience of a permanent colostomy.

Carcinoma of the Urethra.

E. W. RICHES AND T. H. CULLEN (*The British Journal of Urology*, September, 1951) state that carcinoma of the urethra is a rare disease in either sex, but is commoner in females. The peak-age incidence is at about sixty years; examples of the disease in patients under forty years are very exceptional. The present report is based on a series of 34 cases, 15 in men and 19 in women. The authors state that the more anterior the growth, that is, the more distal, the better the prognosis. This is because when the growth is in the deep portion of the canal (*a*) symptoms occur later, or are unrecognized in the early stages, (*b*) it is less accessible to treatment, and (*c*) metastases are more common. In diagnosis, a growth of the urethra demands examination of the bladder, and a growth of the bladder, especially near the neck, demands examination of the urethra. Metastases in inguinal glands are sufficiently common (50%) to warrant consideration of their removal by surgery, or their irradiation, in all cases. Distant metastases occur in about one-third of all cases. Radical surgery is applicable in only a minority of cases, but gives a good prospect of survival. Irradiation is the treatment of necessity in many cases, and provides excellent palliation in some. The tissue from any caruncle in the female, or periurethral abscess in the male, must be examined microscopically.

Duodenal Fistula After Right Nephrectomy.

E. L. CAFFERY AND M. M. MUSSLEMAN (*The Journal of Urology*, February, 1952) state that the active urologist with experience of many removals of the right kidney will encounter the serious complication of injury to the duodenum. It is estimated that this complication occurs in 0·7% of cases. Massive fluid and electrolyte loss occurs, as well as enzymatic tissue digestion. The untreated patient dies of starvation, dehydration, alkalosis and uræmia. The patient's best chance of recovery lies in (i) maintenance of fluid and electrolyte balance, (ii) maintenance of optimal nutrition, and (iii) prevention of tissue digestion. Direct operative attack to close the fistula should be reserved for the patient whose fistula fails to close after vigorous application of the conservative plan.

Urogenital Tuberculosis.

A. J. GREENBERGER AND M. E. GREENBERGER (*The Journal of Urology*, February, 1952) have made an eighteen years' follow-up study of 209 patients operated on for renal and epididymal tuberculosis. Nephrectomy was performed in 63 cases, epididymectomy in 105, and both operations in 41. Chronic pulmonary tuberculosis was present in 50% of the patients who underwent nephrectomy, and in 70·6% of those who underwent epididymectomy. Associated bone tuberculosis occurred in 23·1% of the nephrectomy series and in 22·6% of the epididymectomy series. Post-operative sinuses developed in 38·4% of the nephrectomy series, and in 22·6% of the epididymectomy group. There were 49·9% of known deaths in the whole series. The chief cause of death in both groups was chronic pulmonary tuberculosis. Uræmia is a fairly frequent cause of death after nephrectomy, tuberculous meningitis after epididymectomy.

Carcinoma of the Prostate with Paraplegia.

R. R. ROBERTS AND C. A. KUEHN (*The Urologic and Cutaneous Review*, July, 1951) record a personal case of paraplegia, in a man of fifty-six years, which was found to be due to a bilaterally symmetrical descending degeneration of the lateral cerebrospinal tracts resulting from collapse of the third thoracic vertebra; the destruction of the vertebra was caused by metastasis from prostatic carcinoma. The authors state that only seven cases of paraplegia from this cause could be found in a review of the recent literature; a post-mortem examination was not reported in any of them. The actual disease in the case reported was adenocarcinoma, and the patient was treated by bilateral orchidectomy, followed by œstrogenic therapy. His paraplegia came on about a year later, and his course was steadily downward after that. Bony metastases were widespread, except for the skull. He died in several months. The prostate was found at autopsy to be small, but very hard and firmly fixed in the pelvis. There was a mass of tumour tissue in the hollow of the sacrum, which surrounded the nerve roots as they issued from the foramina. Superiorly this mass was present over the promontory and surrounded the trunks of the fifth lumbar and first sacral nerves, bilaterally. At the time of autopsy, it was thought that this mass accounted for the paraplegia, and so the spinal cord was removed only up to the level of the eighth thoracic vertebra. Subsequent dissection and histological examination showed that the nerves were relatively free from damage, and therefore the paralysis could not be explained on a peripheral basis. The spinal cord was then sectioned at the lumbar enlargement and in the lower thoracic region; severe degeneration of the lateral cortico-spinal tracts was seen in both sections. This could be explained only by a lesion compressing the cord at a higher level. An osteoblastic lesion of the third thoracic vertebra was discovered; this had been overlooked when the X-ray film was originally interpreted, eight months prior to the paraplegia.

British Medical Association News.

ANNUAL MEETING.

THE annual meeting of the Queensland Branch of the British Medical Association was held at British Medical Association House, 225 Wickham Terrace, Brisbane, on September 26, 1952, Dr. K. B. Fraser, the President, in the chair.

REPORT OF THE COUNCIL.

The annual report of the Council for 1952, which had previously been circulated amongst members, was received and adopted, as amended, on the motion of Dr. J. R. Adam, seconded by Dr. J. Lloyd Simmonds. The report is as follows.

The Council has pleasure in presenting the fifty-eighth annual report of the work of the Branch for the period from November 16, 1951, to June 30, 1952. The short period is due to the change in the date of the annual general meeting of the Branch this year from December to September.

Membership.

The membership of the Branch is 959, *plus* seven honorary life members, as against 901 and seven honorary members in 1951, making a total gain of 58. There are also 117 honorary associate members, 33 of whom were elected this year. Fifty-one honorary associate members were elected to full membership on graduation.

The gains were: new members, 83; transfers from other Branches, 25; members reinstated, 13. The losses were: members transferred from Branch *et cetera*, 31; resignations, 4; deceased, 5.

The following, by virtue of their fifty years' membership of the British Medical Association, have become honorary life members: Dr. A. B. Carvosso, Dr. H. R. Cope, Dr. J. A. Goldsmid, Dr. W. Hoare, Dr. T. A. Price (also Honorary Vice-President of the Branch), Dr. E. W. Kerr Scott, and Dr. Woodburn Stevens.

Obituary.

We regret to record the deaths of the following members: Dr. E. J. Davies, Julia Creek; Dr. C. D. Barlow, Mackay; Dr. Harriette M. Voss, Rockhampton; Dr. H. V. Foxton, Brisbane; Dr. R. J. Nash, Brisbane.

Meetings.

In addition to the annual meeting, five general meetings of the Branch were held, including one clinical meeting. The average attendance at the general meetings was 47.

Council.

Ten meetings of the Council were held. Record of attendance is as follows:

Dr. K. B. Fraser (President)	10
Dr. T. V. Stubbs Brown (President-Elect)	10
Dr. G. V. Hickey (Past President)	8
Dr. W. J. Saxton (Honorary Secretary)	9
Dr. F. W. R. Lukin (Honorary Treasurer)	7
Dr. H. W. Horn (Chairman of Council, Federal Council Representative)	10
Dr. H. S. Patterson (Chairman of Subcommittees, Councillor)	9
Dr. B. N. Adsett (Secretary of Subcommittees, Councillor)	7
Dr. A. E. Lee (Federal Council Representative, Councillor)[1]	5
Dr. J. R. Adam (Councillor)	4
Dr. H. W. Anderson (Councillor)	10
Dr. Felix Arden (Councillor)	7
Dr. B. L. W. Clarke (Councillor)	8
Dr. H. R. Love (Councillor)	7
Dr. A. D. A. Mayes (Councillor)	7
Dr. H. M. Saxby (Councillor)	6
Dr. W. H. Steel (Councillor)	9
Dr. J. G. Wagner (Councillor)	7

Scientific.

February.—Clinical meeting in conjunction with the Brisbane Hospital Clinical Society.

March.—Sir Raphael Cilento: "International Adventures in Medical and Social Welfare."

April.—Dr. Noel M. Gutteridge: "World Developments in Clinical Pathology.".

May.—Pædiatric symposium, "Abdominal Pain in Childhood", Dr. K. B. Fraser, Dr. P. A. Earnshaw, Dr. Felix Arden, Dr. H. S. Patterson.

June.—Major-General F. Kingsley Norris: "The Dog and the Shadow" (Bancroft Oration).

Office Bearers and Councillors.

The following office bearers were appointed by the Council for 1952: Chairman of Council, Dr. H. W. Horn (reelected); Honorary Treasurer, Dr. F. W. R. Lukin (reelected); Chairman of Subcommittees, Dr. H. S. Patterson; Honorary Secretary of Subcommittees, Dr. B. N. Adsett (reelected); Honorary Librarian, Dr. Neville G. Sutton (reelected); Honorary Assistant Librarian, Dr. Konrad Hirschfeld (reelected)

Dr. W. J. Saxton was elected Honorary Secretary, and in accordance with the amended by-law the following were elected members of the Council for a period of two years 1952-1953: Dr. J. R. Adam, Dr. B. N. Adsett, Dr. H. W. Anderson, Dr. H. R. Love, Dr. A. D. A. Mayes, Dr. H. M. Saxby, Dr. J. G. Wagner.

Representation.

The Branch was represented as follows during the year.

Council of the British Medical Association.—Dr. Isaac Jones.

British Medical Association Representative Meeting, Dublin, Ireland, 1952.—Dr. H. S. Waters, delegate, Dr. H. D. Ashton.

Federal Council of the British Medical Association in Australia.—Dr. H. W. Horn, Dr. A. E. Lee.

Australasian Medical Publishing Company, Limited.—Dr. Alan E. Lee (director), Dr. T. A. Price, Dr. H. W. Horn (members).

Australian Association for Better Hearing.—Dr. Herbert Earnshaw, Dr. J. R. Hutcheon.

Flying Doctor Service.—Dr. Harold Crawford.

Medical Assessment Tribunal.—Dr. G. W. Macartney.

Medical Board of Queensland.—Dr. R. G. Quinn, Dr. F. W. R. Lukin, Dr. J. G. Wagner.

National Safety Council of Australia (Queensland Division).—Dr. L. A. Little.

Medical Officers' Relief Fund (Federal): Queensland Committee.—Dr. W. H. Steel, Dr. G. W. Macartney, Dr. K. B. Fraser.

Physiotherapy Board of Studies.—Dr. J. R. S. Lahz.

Physical Fitness Association of Queensland.—Dr. E. S. Meyers, Dr. Harold Crawford.

Post-Graduate Medical Education Committee.—Dr. Alan E. Lee, Dr. H. R. Love, Dr. T. V. Stubbs Brown.

Queensland Institute of Medical Research.—Dr. W. H. Steel.

Queensland Health Education Council.—Dr. Felix Arden.

Queensland Bush Nursing Association.—Dr. L. Bedford Elwell.

Queensland Bush Children's Health Scheme.—Dr. Felix Arden.

Surf Life Saving Association of Australia (Queensland Branch).—Dr. F. W. R. Lukin.

Federal Medical War Relief Fund: Local Committee of Management.—Dr. J. G. Wagner (Chairman), Dr. F. W. R. Lukin (Honorary Secretary), Dr. J. V. Duhig, Dr. Harold R. Love, Dr. B. L. W. Clarke.

The Editor of THE MEDICAL JOURNAL OF AUSTRALIA was represented by Dr. Felix Arden.

Ethics Committee.

At the last annual meeting of the Branch the following were again elected to the Ethics Committee: Dr. G. W. Macartney, Dr. Val. McDowall, Dr. L. J. J. Nye, Dr. J. J. Power, Dr. R. G. Quinn, Dr. M. Graham Sutton, Dr. Norman Sherwood.

During the period of this report no meetings of the Ethics Committee were held.

Library.

During the period under review, from November, 1951, to June, 1952, 198 books were borrowed from the library by 50 doctors, including country members. The Branch subscribes to 41 medical journals, also "Year Books", "Medical Annual", "Quarterly Cumulative Index Medicus", "Collected Papers of the Mayo Clinic", "Harvey Lectures", "Medical Research Council Reports" *et cetera*. Two additional journals to which we now subscribe are: *Australasian Annals of Medicine* and *Annals of Physical Medicine*. Twenty-three more text-books on miscellaneous subjects have been received from the Australasian Medical Publishing Company, Limited. Regular use is made of the library by a number of members for reference purposes. The staff is always willing to assist members in every way possible. Inter-library exchange exists between the medical and scientific libraries in Queensland and in the southern States.

[1] On leave from February 23, 1952.

Building Subcommittee.

Personnel.—Dr. M. Graham Sutton (Chairman), Dr. J. G. Wagner, Dr. R. G. Quinn, Dr. A. D. A. Mayes, Dr. J. R. Adam (coopted member), and ex-officio members of the Council.

This subcommittee has been active in reviewing the present conditions and facilities of British Medical Association House, and is considering means for improvement which would not involve the Branch in unnecessary expenditure. The ultimate abolition of the building when it is economically sound to erect new premises on the site, has been kept in mind.

In the recent review of the Valuator-General the Wickham Terrace property has been increased in value from £1650 to £4355. The Bartley Street property was increased from £240 to £400.

Owing to the congestion on Wickham Terrace, the car-parking space at the side of British Medical Association House, which is reserved for members who have temporary business in the premises, has proved a great convenience to those concerned.

Bancroft Oration.

On Friday, June 6, 1952, the thirty-seventh Bancroft Oration was delivered by Major-General F. Kingsley Norris, C.B.E., D.S.O., E.D., M.D., in the lecture theatre of the Medical School of the University of Queensland, at 8.15 p.m., the title being "The Dog and the Shadow". There was an attendance of 75, and the Oration was aptly described as a "perfect gem and kept the large audience enthralled for one and a half hours".

It was decided by the Council to obtain a number of reprints of the Oration for distribution to the 1952 medical graduates of the University of Queensland and to various persons outside the medical profession.

At the conclusion of the Oration the President presented the Bancroft Memorial Medal to Major-General Kingsley Norris.

Organization Subcommittee.

Personnel.—Dr. H. S. Patterson (Chairman), Dr. Alan E. Lee, Dr. J. G. Wagner, Dr. B. L. W. Clarke, Dr. Harold R. Love, Dr. J. R. Adam, Dr. H. W. Anderson, Dr. H. M. Saxby, and ex-officio members of the Council.

During the period under review eleven meetings were held.

The work of this subcommittee is important, as it considers the official correspondence and deals with matters which do not involve policy. Where appropriate it makes recommendations to the Council.

By-laws: Amendments.

At the last annual meeting of the Branch held on December 14, 1951, amendments to the following by-laws were adopted: By-laws 4 and 4(*b*), "Members' Subscriptions"; 53(*b*), 57 and 65, "Contract Attendance Friendly Society Lodges"; 69, "Affiliated Local Association of Members"; 87 (7) and (8), "Rules Governing the Conduct of Members in Regard to Fees in Private Practice". Members were subsequently notified of these amendments.

Medical Fees Tribunal.

Personnel.—Dr. J. G. Wagner (Chairman), Dr. Alan E. Lee (Honorary Secretary), Dr. G. W. Macartney, Dr. H. S. McLelland, Dr. R. G. Quinn, Dr. Norman Sherwood, who acted as Honorary Secretary *pro tempore* during Dr. Lee's absence abroad.

Two meetings of the tribunal were held during the period under review to deal with cases submitted by the Council.

Workers' Compensation—Schedule of Fees.

In November last the Insurance Commissioner was approached with a request that an increase in certain basic fees in the Schedule be granted, *viz.*, first domiciliary attendance to be increased to 17s. 6d. and subsequent attendances to 12s. 6d., provided that when there are two attendances only the fee for each attendance be 17s. 6d. Maximum weekly payments: first week £3 3s., second and subsequent weeks £2 2s. Specialist fees: subsequent attendances increased from 15s. to £1 1s. The Commissioner stated that the present Schedule was adopted (in July, 1951) after a thorough survey of the position, and he could see no real justification for any amendment of the Schedule, and regretted he could not agree to the suggested increases.

The Medico-Legal Society of Queensland.

The inaugural meeting of the Medico-Legal Society of Queensland was held in the Brisbane Chamber of Commerce Rooms, Adelaide Street, Brisbane, on Wednesday, May 21, 1952, at 8 p.m.

There was a very representative gathering of members of the three bodies which compose the Society—the Bar Association of Queensland, the Queensland Law Society Incorporated, and the Queensland Branch of the British Medical Association.

The Chief Justice of Queensland, the Honourable N. W. Macrossan, was elected President. Dr. T. V. Stubbs Brown and the Honourable Mr. Justice Townley were elected Vice-Presidents. Mr. N. V. Henderson was elected Honorary Treasurer, and Dr. W. J. Saxton and Mr. W. S. Simpson were elected Honorary Secretaries of the Society.

The Committee is composed of three representatives each of the Bar Association and the Queensland Law Society, and four respresentatives of the British Medical Association, who are Dr. F. W. R. Lukin, Dr. Neville G. Sutton, Dr. R. G. Quinn, and Dr. O. S. Hirschfeld.

Pharmaceutical Benefits Act.

The provision of pharmaceutical benefits has continued during the year, but the Schedule of Drugs has undergone marked contraction. Some drugs have been deleted, while the more expensive antibiotics have been placed under control by Regulation 14A. This has resulted from the Government's alarm over the ever increasing costs of the service, and in particular over increases alleged to be due to misuse of valuable drugs by some doctors. Your Council has considered such allegations and has represented to the Federal Council the urgent need for the establishment of State supervisory committees of the British Medical Association, protected by statutory powers, to deal with alleged offences under the Act. The Minister has approved of this principle, but up to date the necessary legislation has not been implemented.

Pensioner Medical Service.

The Pensioner Medical Service is generally agreed to have provided a satisfactory family doctor service to pensioners, although there are still some areas where doctors are unwilling to participate. The Council has attempted to rectify this in the interests of pensioners who are thus denied the service, and their failure can only be ascribed to a shortage of doctors in such areas. Controversy has arisen with the Government in respect of an increase in fees, the present amounts of 8s. 6d. and 10s. being regarded as too concessional, and amounts of 10s. 6d., and 12s. 6d. have been sought. Here again over-attendance and other irregularities have been alleged against certain doctors, and it would appear that control by supervisory committees is desirable.

Medical Service to Members of Friendly Societies.

The change over from the lodge capitation fee to the fee-per-service method of payment was introduced on January 1, 1952.

The only matters which have caused any comment have been (*a*) the currency of the "on certificates", and (*b*) the issue of certificates to enable lodge members to obtain their benefits where the friendly societies require the nature of the disease to be stated. The latter difficulty may be solved by the doctor giving the patient the information in cases of confinement and of those operative procedures, benefits for which are laid down in the lodge schedule. The position in regard to certificates is that the original "on" certificate will have a currency of twenty-eight days or any less period which the medical practitioner considers would cover the patient's disability. Such certificates are given free except where a friendly society demands fortnightly certificates. No standard certificate has yet been drawn up by the friendly societies.

Medical Ethics.

A memorandum on the subject of medical ethics in the light of present day practice has been drawn up and is under consideration by a special subcommittee.

Examination of National Service Trainees.

A letter was received from the Registrar of the Department of Labour and National Service expressing appreciation of the excellent assistance given by members in examining trainees for national service under the *National Service Act.*

Sections for Study of Special Branches of Medical Knowledge.

Medical Historical.

Professor H. J. Wilkinson (Chairman), Dr. G. B. V. Murphy (Honorary Secretary).

The Section of Medical History of the British Medical Association (Queensland Branch) reports that it has received the furnishings of the consulting room of the late Sir David Hardie, and these have been placed in a special room which has been set aside for them in the department of anatomy awaiting a more suitable place.

The course of lectures on the history of medicine was given again this year to senior medical students by the Chairman, Professor H. J. Wilkinson, who is the Honorary Lecturer of the History of Medicine at the Medical School. The Chairman is taking part in the sesquicentenary celebrations of Leonardo da Vinci, which are to take place in Brisbane on Wednesday, August 27, where he is giving an address on Leonardo as an anatomist and physiologist.

The committee, as always, is looking forward to receiving interesting information and exhibits.

H. J. WILKINSON,
Chairman, Section of Medical History.

Obstetrical and Gynæcological.

Dr. Robin Charlton (Chairman), Dr. Roy Hemsley (Honorary Secretary).

Regarding the activities of the Society during the past twelve months, I have to report only one general meeting. This was held to discuss the question of specialist fees relating to obstetrical and gynæcological procedures. A report has already been made concerning these matters. It was further decided that all office bearers of the Society be reelected.

The committee later decided that no scientific meeting would be held till October or November of this year, as there was quite a considerable obstetrical programme in view, owing to the visit of Dr. Dixon Hughes of Sydney, the Post-Graduate Week and the visit of the Sims-Black Travelling Professor in Obstetrics and Gynæcology. It was felt that too many lectures would result in poor attendances.

However, the committee realizes that there is a very real interest in the Society amongst the general practitioners and looks forward to providing further meetings in the latter months of the year.

ROY HEMSLEY,
Honorary Secretary.

Ophthalmological.

Dr. C. M. Matheson (President), Dr. Andrew Harrison (Honorary Secretary).

Membership of the Queensland branch of the Ophthalmological Society of Australia (British Medical Association) is twenty-five.

Five meetings have been held, including two clinical meetings, one at the Mater Misericordiæ Hospital and the other at the Brisbane General Hospital. Films of eye operations, which were obtained from the Post-Graduate Committee of Sydney, were also shown.

An attempt has been made to improve the orthoptic service at the Brisbane General Hospital and the Children's Hospital.

A. HARRISON,
Honorary Secretary.

Oto-Rhino-Laryngological.

Dr. L. T. Jobbins (Chairman), Dr. C. Wark (Honorary Secretary).

The above Section held four meetings during the year, including demonstrations of the work of the Commonwealth Acoustic Laboratory, and of the Speech Therapy Clinic of the Department of Mental Hygiene.

A clinical meeting was held at Brisbane General Hospital, and also a presentation of case histories of interest.

C. WARK,
Honorary Secretary.

Pædiatrics.

Dr. P. A. Earnshaw (President), Dr. N. G. Anderson (Honorary Secretary).

This Section held several business meetings during the year, which were well attended. At the July, 1951, meeting Dr. A. E. Paterson was nominated as the Section's representative to the Australasian Medical Congress (British Medical Association), Melbourne, August, 1952. Clinical meetings, which are held alternatively at the Hospital for Sick Children and the Mater Misericordiæ Children's Hospital, took place in July, 1951, December, 1951, and April, 1952.

A symposium in conjunction with the monthly British Medical Association meeting for May was also arranged by the Section, the subject being "Abdominal Pain in Childhood", at which the principal speakers were Dr. K. B. Fraser, Dr. Felix Arden, Dr. H. S. Patterson and Dr. P. A. Earnshaw.

A film evening was held at the residence of Dr. T. R. Biggs on August 29, 1951, at which four films of pædiatric interest were shown.

The group contains fourteen members.

NEVILLE G. ANDERSON,
Honorary Secretary.

Affiliated Local Associations.

Annual Conference.

The annual conference of Local Associations (British Medical Association) and members of the Council of the Branch was held at British Medical Association House on Wednesday, June 4, 1952, from 9 a.m. to 1 p.m.

The following Local Associations were represented: Ipswich and West Moreton, Dr. R. V. Adamson; Downs and South Western, Dr. V. R. Woodhill, Dr. J. W. P. Henderson; Bundaberg, Dr. John Hains; South Burnett, Dr. R. J. C. Dark, Dr. F. H. Cowlishaw; Cairns, Dr. C. H. Knott; Nambour and District, Dr. B. S. Skerman; South Coast, Dr. O. N. Lloyd; Lower Burdekin, Dr. C. Constable.

Dr. L. P. Winterbotham (Chairman) and Dr. A. D. Isles (Honorary Secretary) of the General Practitioner Group were present by invitation.

Apologies were received from Rockhampton, Townsville and Maryborough Local Associations.

The President, Dr. K. B. Fraser, welcomed the visitors and said what a valuable opportunity the annual conference provided for the Council and representatives of country members to meet and discuss problems affecting the profession.

Among the matters discussed were the following: Medical Benefits Fund of Australia, Pensioner Medical Service, shortage of nurses in country districts, medical ethics, remuneration of part-time medical superintendents of hospitals, dental anæsthesia, pharmaceutical benefits (restriction of antibiotics), post-graduate medical education, new form of annual Branch meeting.

Nambour District Local Medical Association

Our office bearers for the ensuing year are: President, Dr. H. L. Kesteven; Honorary Secretary and Treasurer, Dr. J. E. Trotter.

The Nambour and District Association has had what may be considered another succesful year of functioning and cooperation. Unfortunately, our equilibrium has been upset somewhat by the moving on of older members, whose support we miss. However, their successors are filling the bill adequately and stirring us to greater thought.

Our meetings have been few but successful, entertaining and instructive, particularly those at which we have had guest lecturers under the auspices of the Post-Graduate Committee.

Our endeavours to set the Medical Benefits Fund of Australia on a firm footing in our district have met with marked success. Fortunately, we have had no trouble with the Pensioner Medical Scheme and pharmaceutical benefits prescribing *et cetera*—except, of course, the inevitable and wearisome form-filling—and are all working well and in unison.

J. E. TROTTER,
Honorary Secretary.

Ipswich and West Moreton Medical Association.

The annual meeting and dinner were held at the Palais Royal Hotel, Ipswich, on February 21, 1952. The President of the Queensland Branch (Dr. K. B. Fraser), the Honorary Secretary (Dr. W. J. Saxton), and the Chairman of Council (Dr. H. W. Horn) were present as guests.

The following office bearers were elected: President, Dr. R. V. Adamson; Honorary Secretary, Dr. H. M. Saxby.

The annual subscription for 1952 was fixed at £1 1s. for members in private practice in Ipswich and 10s. 6d. for country, non-practising and resident medical officer members. Membership of the Association as at June 30, 1952, was twenty-seven.

Social Activities.—On November 25, 1951, golf and bowls matches were played against Brisbane colleagues. This was an enjoyable reunion. On December 21, 1951, a Christmas cocktail party was held in conjunction with members of the Ipswich Branch of the Australian Dental Association and of the Ipswich and West Moreton Zone of the Federated Pharmaceutical Service Guild. This was a successful function which it is hoped to make an annual event.

Meetings.—These were held as follows: July, 1951: Dr. H. W. Horn lectured on the subject of "Management of

Difficult Labour and Emergencies in Obstetrics". August: "Surgery of the Hand", by Dr. A. R. Murray. September: "Ear, Nose and Throat Work and the General Practitioner", by Dr. S. C. Suggit. October: Film evening at which were shown films entitled (*a*) "Diagnosis and Treatment of Eclampsia", (*b*) "Surgery of Patent Ductus Arteriosus", (*c*) "English Rehabilitation Services". November: "Foot Complaints", by Dr. T. V. Stubbs Brown. December: Business meeting. February, 1952: Annual meeting and dinner at the Palais Royal Hotel. March: "Diagnosis and Treatment of Common Skin Conditions", by Dr. O. E. Nothling. April: "Trends of Antibiotic Research", by Dr. H. M. Walker. May: Presentation and discussion of case histories; the cases were as follows: (*a*) Dr. R. V. Adamson, "Hæmorrhage of Obscure Origin"; (*b*) Dr. K. Rawle, "Intermittent Jaundice"; (*c*) Dr. L. J. O'Keefe, "Oculo-motor Palsy"; (*d*) Dr. R. V. Adamson, "An Example of the Recuperation of Muscles Six Years After Anterior Poliomyelitis"; (*e*) Dr. P. H. Foote, "The Use of Calcium Pantothenate in Paralytic Ileus"; (*f*) Dr. D. A. Carter, "Experiences with the Use of 'Estopen'"; (*g*) Flight-Lieutenant D. H. Prentice, "A Problem in Epilepsy". June: Demonstration, "Clinical Methods in the Diagnosis of Cardiac Disease", by Dr. H. G. Wilson.

It is desired to thank the Post-Graduate Medical Education Committee and lecturers for their cooperation, and also the Ipswich Hospital Board and Matron for the provision of meeting and lecture room facilities and supper at the conclusion of meetings.

South Coast Local Association.

The activities of the South Coast Local Association have been more restricted over the past year owing to less contentious problems. Since October, 1951, only two lectures have been given by visiting lecturers, namely, Dr. N. M. Gutteridge and Dr. L. D. Walters. As usual they were very greatly appreciated, and it is very much regretted that the number of lectures this year has been so drastically reduced.

One problem which arose during the year was the excessive fee charged for diversion of calls for week-end duty roster by the Postmaster-General's Department. A protest through the Local Association has been successful in effecting a reduction of the charge.

Following a recommendation from the annual conference of Local Associations in June, 1952, regarding dental anæsthetics, representatives of this Association met the local dentists and arrived at satisfactory decisions regarding decreasing the risks of dental anæsthesia.

R. LEVY,
Honorary Secretary.

Mackay Local Medical Association.

In common with other Branches of the British Medical Association, lodge contract practice, as such, ceased on December 31, 1951. The change-over occurred quite smoothly despite gloomy prognostications by lodge secretaries.

Under the leadership of the Government Medical Officer (Dr. I. Chenoweth) an attempt has been made to discover the incidence of goitre in Mackay and district. An examination of necks of a fair percentage of the population has produced some interesting findings. Otherwise the year has been very quiet. No post-graduate lectures have been held.

Papers read by local practitioners have been: "Position and Posture", by Dr. M. J. Gallagher; "Urinary Calculus", by Dr. P. W. Hopkins; "Interim Report on Incidence of Goitre in Mackay and District", by Dr. I. H. Chenoweth; "Swellings of the Breast", by Dr. S. C. Williams.

S. C. WILLIAMS,
Honorary Secretary.

South Burnett Medical Association.

The Association has a membership of eleven.

Four meetings were held during the year and these were as follows:

October 16, 1951, held in Kingaroy. Dr. Dark was elected President and Dr. Cowlishaw Secretary. Dr. Trevor Parry was the visiting lecturer and gave a talk on cardiology. The meeting was attended by nine members.

December 22, 1951, held in Nanango. No visiting lecturer. The new scale of fees was discussed, and it was decided to raise fees in accordance with the British Medical Association memorandum, except for consultation and mileage rates, which remained as before. Other matters were dealt with. Seven members attended.

March 15, 1952, held in Wondai. Seven members attended the meeting, at which Dr. Murray Elliott was the visiting lecturer and gave a talk on gynæcology. At the meeting it was decided to raise the consultation fee to 15s. and mileage rates were left to individual discretion. Other minor "domestic" matters were discussed.

May 17, 1952, held in Nanango. There was no visiting lecturer. There was a long discussion regarding matters to be brought up at the Local Association conference. The representatives were to be Dr. Dark and Dr. Cowlishaw. Amongst other matters it was decided to communicate with the Postmaster-General's department regarding the night telephone services at the various centres complaining of gross inadequacies. Attended by seven members.

F. H. COWLISHAW,
Honorary Secretary.

Townsville Local Association.

The activities of the Townsville Local Association during 1952 began with the annual general meeting on February 19, 1952. The election of officers for the year 1952 resulted in Dr. P. J. Monahan being elected President and Dr. K. L. King Honorary Secretary-Treasurer.

It was decided that the Townsville Local Association would meet every second Tuesday and that activities would be arranged by a programme committee.

The schedule has been as follows:

March 4, 1952: Clinical demonstrations of leprosy. After examination of cases, Mr. Ley spoke on the orthopædic treatment of these cases, Dr. Remington gave an outline of the pathology of leprosy, and Dr. Dorney concluded with a description of the treatment at Fantome Island.

March 18, 1952: A combined clinical and business meeting was held.

March 28, 1952: A special meeting of the Townsville Local Association was called to discuss the shortage of nurses. This meeting was held prior to a public meeting called by His Worship the Mayor on the same subject.

Clinical meetings: The cases being presented by members of the hospital staff were arranged for April 1 and April 15, 1952.

Dr. I. Mackerras delighted us with a lecture on April 29. In his talk he outlined the growth of his Institute of Medical Research, the method of attacking research problems, and sketched for us the field work his party was engaged in at Townsville.

A clinical meeting on May 27, 1952, was followed on June 10, 1952, by a film evening by courtesy of T. J. Smith and Nephew. The films shown were (i) "Fracture of the Forearm", (ii) "Varicose Veins", (iii) "Varicose Eczema".

This concluded the activities of the Townsville Local Association up to June 30.

Rockhampton Local Association.

The Rockhampton and District Local Association of the British Medical Association had a most successful year from both the professional and social point of view.

Dr. W. E. Hasker was elected President, Dr. E. R. Watkins Vice-President and Dr. J. F. Gillogley Honorary Secretary.

In the absence of post-graduate lecturers, it was realized that there was an even greater need than before for local clinical meetings. This association has to thank Dr. J. Fullagar, Superintendent of the Rockhampton General Hospital, and his staff, who have now taken over the organization of monthly clinical meetings, at which a local practitioner presents a paper and the hospital staff presents clinical cases.

From the social point of view, Dr. and Mrs. Hasker presided over a delightful Christmas cocktail party. The annual dinner was also a great success.

The present membership is thirty-seven and one honorary member.

Medical Benefits Fund of Australia (Queensland Branch).

During the past year the Medical Benefits Fund of Australia has operated in Queensland with great success. The general public are obviously appreciating the benefits of pre-payment systems of medical and hospital insurance, and when the Commonwealth subsidies become available the flood of applicants is likely to tax the office staff of the fund to its utmost.

Already the number of new applications has exceeded 3000 for one month, and reserve funds of more than £12,000 have been invested.

While much of the success of the fund must be attributed to the enthusiastic efforts of its manager, Mr. K. J. Allison, a great deal of the administrative work and adjudication on claims is done at regular meetings of the Executive Com-

mittee, which consists of six doctors and a layman, Mr. L. J. McCray, President of the Chamber of Manufacturers, all of whom act in an honorary capacity.

It is highly desirable that those members of the profession who have not yet enrolled as medical members should do so, and thus show their personal interest in the welfare of what is after all their own fund and also that they should continue to bring the fund before the notice of their patients.

British Medical Agency of Queensland, Proprietary, Limited.

The number of doctors engaging assistants and to a lesser extent taking partners is pronounced, and the services of the Agency in arranging introductions and/or supplying information for the respective parties to arrive at an equitable understanding have been in strong demand.

It is noticed that there is a swing towards the formation of group practices, and here again the Agency has proved of considerable assistance.

Practices continue to change hands, perhaps more readily now than some few months ago, and this may be due to the easing in property values and the close relationship to supply and demand.

The Agency continues to supply stationery, furniture for professional rooms and other requirements, all of which activities safeguard members financially.

Another satisfactory year is reported.

Queensland Medical Finance, Proprietary, Limited.

Funds available are somewhat limited, but it has been possible to satisfy recent requests.

Applications from members seeking financial assistance in the purchase of medical practices receive every consideration.

S. N. COBBOLD,
Secretary.

Honorary Associate Members.

The number of honorary associate members of the Branch has increased to 117. In March last a letter was received from the British Medical Association advising that from January 23, 1952, the subscription payable by medical students for the *British Medical Journal* was increased from 10s. 6d. to £1 1s. (sterling) *per annum* (£1 5s. 6d. Australian). This increase did not apply to those associate members who had already paid their subscriptions prior to receipt of the advice from the London office.

Training of Students in General Practice.

Early in the year a letter was received from the University of Queensland stating that the Faculty of Medicine had under consideration the proposal that sixth year medical students should be required to spend some weeks as observers with general practitioners and asking that the Association ascertain how many of our general practitioner members would be prepared to cooperate. The response from members so far has not been as satisfactory as expected. It is realized that the suggestion, although fraught with difficulties, would be beneficial to the students. A subcommittee has been appointed to go further into the matter, and those who have not already agreed to take part are asked to reconsider the question.

Queensland Post-Graduate Medical Education Committee.

The representatives of the Branch are Dr. Alan E. Lee, Dr. H. R. Love and Dr. T. V. Stubbs Brown.

Owing to heavy financial commitments the programme of post-graduate activities has had to be considerably modified during 1952. As an economy measure publication of the *Queensland Post-Graduate Medical Journal* has been suspended during 1952, and country tours have had to be considerably reduced. In the first six months of 1952 only eight such tours were made, as compared with 18 during the second six months of 1951.

Visiting lecturers from overseas have included Sir Edward and Lady Mellanby, Professor E. C. Dodds, Professor Le Gros Clark and Professor C. H. Best, all of whom lectured in Brisbane.

Seventy-one doctors enrolled for post-graduate week, 1952.

The committee arranged the following courses suitable for candidates studying for higher degrees and diplomas: pathology, 1951, 21 attended; advanced medicine, 1952, 11 attended; anatomy, 1951, 20 attended; D.P.M. Part I, 1951, five attended; obstetrics and gynæcology, 1951, six attended. This latter was a full-time course of one week's duration, and Dr. T. Dixon Hughes was invited to take part during the last week-end. For the benefit of country practitioners who cannot leave their practices at the time a course is being held, the committee has arranged with the authorities at the Brisbane Women's Hospital for short-term residence to be arranged for such practitioners, during which they will be able to take advantage of the full range of hospital activities and gain much valuable post-graduate instruction from the visiting staff.

During the year nine Queensland doctors who went overseas for post-graduate study were granted sponsorship.

It is hoped that post-graduate activities throughout Queensland may return to their former level in 1953. The committee acknowledges its grateful appreciation to the Queensland Branch of the British Medical Association and to the University of Queensland for financial assistance, which will enable it to start the year 1953 in a financially sound position.

Federal Council of the British Medical Association in Australia.

During the period under review, one meeting of the Federal Council of the British Medical Association in Australia was held in Hobart from February 25 to 27, 1952.

The Branch was represented by Dr. Alan E. Lee and Dr. H. W. Horn.

The second meeting will take place in Melbourne on August 21, 1952.

British Commonwealth Medical Conference.

At the third British Commonwealth Medical Conference, which was held in Calcutta, India, on March 20-23, 1952, the British Medical Association in Australia was represented by a member of the Queensland Branch, Dr. Alan E. Lee, who was elected by the Federal Council to fill this position.

Australasian Medical Congress (British Medical Association).

Eighth Session.

The eighth session of the Australasian Medical Congress (British Medical Association) will be held at Melbourne on August 22 to 29, 1952.

Dr. Glen V. Hickey has been appointed a Vice-President of Congress and Dr. W. J. Saxton Honorary Local Secretary on the nomination of the Council.

A total of fifty-four members from Queensland has joined Congress to date.

The following members of the Branch have been appointed Presidents and Vice-Presidents of Sections of Congress:

Presidents: Surgery, Professor Neville G. Sutton; Public Health, Industrial Medicine, Tropical Medicine and Aviation Medicine, Dr. E. H. Derrick.

Vice-Presidents: Anæsthesia, Dr. A. W. Robertson; Dermatology, Dr. A. J. Foote; Medicine, Dr. H. R. Love; Naval, Military and Air Force Medicine and Surgery, Colonel F. G. Scoles; Neurology and Psychiatry, Professor J. Bostock; Obstetrics and Gynæcology, Dr. J. C. Hemsley; Ophthalmology, Dr. D. C. McSweeney; Oto-Rhino-Laryngology, Dr. S. C. Suggit; Pathology, Bacteriology, Biochemistry, Experimental Medicine and Forensic Medicine, Dr. J. V. Duhig; Pædiatrics, Dr. A. E. Paterson; Radiology and Radiotherapy, Dr. C. W. Uhr.

Social.

Instead of the usual annual ball it was decided to hold a fork dinner as the Branch social function of the year. The conveners were Dr. B. L. W. Clarke and Dr. B. N. Adsett, who arranged a very enjoyable party at 29 Murray Street on Wednesday, June 4, during Post-Graduate Week. It was voted a huge success by the members, wives and friends who attended, as this form of entertainment provides a better opportunity for the guests to meet each other than is the case at a formal ball. Major-General Kingsley Norris was a guest.

Prior to the Bancroft Oration the President arranged a small dinner party at which Major-General Kingsley Norris was the guest of honour.

Following the Conference of Representatives of Affiliated Local Associations (British Medical Association) held on the morning of June 4, country representatives were entertained at luncheon by members of the Council at the United Service Club.

Conclusion.

This year has been a busy one for the Council, although no major crises have arisen.

QUEENSLAND BRANCH OF THE BRITISH MEDICAL ASSOCIATION (INCORPORATED).

Revenue Account for period November 16, 1951, to June 30, 1952.

EXPENDITURE.	£ s. d.	£ s. d.
June 30, 1952—		
To Branch Expenses	1,643 18 7	
„ Library Expenditure	208 19 6	
„ Depreciation of Equipment	9 6 4	
		1,862 4 5
„ Subsidy — Post-Graduate Committee		400 0 0
„ Provision for Staff Superannuation		80 0 0
„ Federal Council— Capitation Fees		928 4 0
„ Balance carried down		1,545 19 9
		£4,816 8 2
June 30—		
To Provision for Long Service Leave		165 19 0
„ Net Surplus for Year, transferred to Accumulation Account		1,380 0 9
		£1,545 19 9

INCOME.	£ s. d.	£ s. d.
June 30, 1952—		
By Branch and Organization Fund— Subscriptions		4,361 3 9
„ Portion of Journal Subscriptions, to be invested in Australasian Medical Publishing Company, Limited, Sydney, Series "E" Debentures		206 5 0
		4,567 8 9
„ British Medical Association House and Bartley Street Property— Rents	374 7 2	
Less— Depreciation £61 6 11; Other expenses £277 16 4	339 3 3	35 3 11
„ Interest— Commonwealth Government Inscribed Stock	29 5 0	
Australasian Medical Publishing Company, Limited	17 9	30 2 9
„ General— Proceeds Clerical Assistance and Sundries	172 12 7	
Sale of Diet Sheets and Lists of Members	11 0 2	183 12 9
		£4,816 8 2
June 30—		
By Balance brought down		1,545 19 9
		£1,545 19 9

GENERAL FUND.

Statement of Receipts and Payments for period November 16, 1951, to June 30, 1952.

RECEIPTS.	£ s. d.	£ s. d.
November 16, 1951—		
To Funds at November 16, 1951— English, Scottish and Australian Bank, Limited— Current Account	4,974 9 7	
Cash	22 14 1	4,997 3 8
June 30, 1952—		
To Subscriptions— Queensland Branch Subscriptions	2,959 12 9	
Organization Fund, Queensland Branch	1,401 11 0	
For remittance to British Medical Association, London	1,150 10 0	
For remittance re Medical Journal	903 3 0	
Medical Students' Loan Fund	80 1 0	6,494 17 9
„ General— Clerical Assistance and Hire of Office Equipment	214 0 0	
Rents— B.M.A. House £30 0 0; Bartley Street property 149 7 2	179 7 2	
Proceeds sale Diet Sheets, Lists of Members and Sundry Income	53 12 9	
Interest on Commonwealth Inscribed Stock	29 5 0	
Australasian Medical Publishing Company, Limited —*Interest on Funds Held*	17 9	477 2 8
		£11,969 4 1

PAYMENTS.	£ s. d.	£ s. d.
June 30, 1952—		
By Amounts remitted on account of Subscriptions *collected to*— British Medical Association, London	1,139 4 0	
Australasian Medical Publishing Company, Limited, Sydney—for publication of journals	683 5 0	
Applied to Series "E" 3½% Debentures	206 5 0	
Medical Students' Loan Fund	64 11 0	2,093 5 0
„ Federal Council— Capitation Fee (1952)		928 4 0
„ Branch Expenses— Salaries, Audit and Honoraria	1,146 5 5	
Printing, Stationery, Postages and Telephone	381 0 0	
Bank Charges, Lighting and Sundries	104 3 8	1,631 9 1
„ B.M.A. House Expenses— Rates to 30/6/1952	105 11 1	
State Land Tax, Insurance and Maintenance	131 13 7	
	237 4 8	
„ Bartley Street Property— Rates to 30/6/1952	15 18 9	
Insurance and Sundries	24 12 11	
	40 11 8	277 16 4
„ General— *Inscribed Stock* — City Electric Light Co. Ltd.	2,000 0 0	
Shares — British Medical Agency of Queensland, Proprietary, *Limited*	742 0 0	
Subsidy—Post-Graduate Committee	400 0 0	
Library Expenditure	208 19 6	
Purchase—Equipment	137 11 4	
Transfer to Superannuation Fund	80 0 0	3,568 10 10
„ Funds at June 30, 1952— English, Scottish and Australian Bank, Limited, Brisbane	*3,449 18 10*	
Cash	20 0 0	3,469 18 10
		£11,969 4 1

QUEENSLAND BRANCH OF THE BRITISH MEDICAL ASSOCIATION (INCORPORATED).

Balance Sheet as at June 30, 1952.

	£ s. d.	£ s. d.
Fixed Liabilities—		
Loan from Queensland Medical *Land Investment Company*, Limited		4,650 0 0
Current Liabilities—		
Provision for Long Service Leave	165 19 0	
Accrued Charges	11 17 0	
Subscriptions for remittance to—		
British Medical Association, London .. £50 10 3		
Australasian Medical Publishing Company, Ltd., Sydney £36 5 6		
Medical Students Loan Fund .. £15 10 0		
	102 5 9	280 1 9
Association Funds—		
Sinking Fund	2,573 4 3	
Superannuation Fund	793 8 1	
Accumulation Fund	13,151 2 2	
		16,517 14 6
		£21,447 16 3

	£ s. d.	£ s. d.
Fixed Assets, at cost, less depreciation—		
Land and Buildings—		
British Medical *Association* House .. £2,229 14 11		
Bartley Street *Property* .. £1,480 11 8		
	3,710 6 7	
Typewriters, Book Cases, Balopticon and Furniture	302 18 2	
Architect's Fees — preparing plans for prospective new building, at cost	300 0 0	
Library—at valuation	150 0 0	
Bancroft Medals and Collar	2 5 0	
Wire Recorder	34 4 0	
Refrigerator Installation	72 11 10	
		4,572 5 7
Investments—		
Queensland Medical Land Investment Company, Limited, 5950 Shares of £1 each, paid to 10s.—each at cost	2,975 0 0	
City Electric Light Company, *Limited, £2,000 4½% Inscribed* Stock—at cost	2,000 0 0	
British Medical Agency of Queensland, Proprietary, Limited, 1000 Shares of £1 each—fully paid at cost	1,000 0 0	
	5,975 0 0	
Australasian Medical Publishing Company, Limited, Sydney—		
5% Series "C" Debentures, at cost	50 0 0	
5% Series "D" Debentures, at cost	5 0 0	
3¾% Series "E" Debentures, at cost	1,600 0 0	
Advance not yet converted to Series "E" Debentures	63 19 6	
	1,718 19 6	
		7,693 19 6
Current Assets—		
Australian Consolidated Inscribed Stock, at cost—		
3¼% maturing 15/9/1959 .. £1,500 0 0		
3¼% maturing 15/10/1960 .. 300 0 0		
	1,800 0 0	
English, Scottish and Australian Bank, Limited	3,449 18 10	
Sundry Debtors	539 0 0	
Cash	20 0 0	
Electric Light Deposit	6 0 0	
		5,814 18 10
Fund Investments—		
Sinking Fund—		
Australian Consolidated Inscribed Stock—		
£280 3¼% maturing 15/12/1965, at cost	280 0 0	
£90 3¼% maturing 15/10/1960, *at cost*	90 0 0	
£2,000 3¼% maturing 15/8/1964, at cost	2,000 0 0	
Commonwealth Savings Bank, Brisbane	203 4 3	
	2,573 4 3	
Superannuation Fund—		
Commonwealth Savings Bank, Brisbane	793 8 1	
		3,366 12 4
		£21,447 16 3

Note.—No provision has been made for income taxes to be assessed on the income of the current period.

Auditors' Report.—We have compared the above Balance Sheet with the books, accounts and vouchers of the Queensland Branch of the British Medical Association (Incorporated), and have obtained all the information and explanations we have required.

In our opinion, the Balance Sheet is properly drawn up to exhibit a true and correct view of the state of the Association's affairs as at June 30, 1952, according to the best of our information and the explanations given to us, and as shown by the books of the Association.

The Register of Members and other records which the Company is required to keep by the Companies Acts of 1931-1942, or by its Articles, have, in our opinion, been properly kept.

R. G. GROOM AND COMPANY,
Chartered Accountants (Aust.),
Auditors.

F. LUKIN,
Honorary Treasurer.

Brisbane,
August 12, 1952.

The details of the *Pharmaceutical Benefits Act* and the Pensioner Medical Service after various vicissitudes are *gradually becoming stabilized.*

The Commonwealth Government expects to bring down the *National Health Service Act* in the near future. This scheme *embodies two principles of outstanding importance* to the profession: firstly the retention of the doctor-patient relationship, and secondly the right of free choice of doctor. *It is confidently expected that the profession on its part will* continue to give that conscientious service to the public for which it has always been noted when the National *Health Service Scheme is implemented in its entirety.*

Three Councillors, Dr. F. W. R. Lukin, Dr. G. V. Hickey and Dr. F. W. Arden, all of whom have rendered loyal service to the Council, are not seeking reelection. *Dr. Lukin* has been a Councillor for over twenty years, and has been both President and Honorary Treasurer; his presence at *Council debates will be sadly missed. Dr. G. V. Hickey, who* was President in 1951, has for a long period travelled regularly to Council meetings from Toowoomba; both he and *Dr. Arden, who has been on the Council for a consider*able time, will also be missed.

Once again we pay tribute to our Secretary, Mrs. Spooner, who with her efficient staff has so materially lightened the burden of the Council. I would like personally to thank all *members of the Council and particularly the office bearers for* the consistent support they have given me during my term of office.

My good wishes are extended to my successor, Dr. T. V. Stubbs Brown, who will I am sure enjoy his term as President with the new Council as much as I have enjoyed *mine with the old.*

In February, 1952, the Empire suffered a grievous loss in the death of His Majesty King George VI. He will be remembered *for the selfless devotion he showed to his* people throughout his reign and for the quiet courage with which he faced the "slings and arrows of outrageous fortune".

We welcome our new Sovereign, Her Most Gracious Majesty Queen Elizabeth, with the fervent prayer that she *will have a long* and glorious reign.

K. B. FRASER,
President.

BALANCE SHEET AND FINANCIAL STATEMENT.

The balance sheet and financial statement for the period *ended June 30, 1952, copies of which had been circulated to* members, was adopted on the motion of Dr. H. W. Horn, seconded by Dr. B. N. Adsett.

OFFICE BEARERS.

The President announced the names of the office bearers *for the ensuing years:*

President.—Dr. T. V. Stubbs Brown.

President-Elect.—Dr. W. J. Saxton.

Past President.—Dr. K. B. Fraser.

Honorary Secretary.—Dr. D. A. Henderson.

Members of Council.—Elected for two years: *Dr. B. L. W.* Clarke, Dr. H. W. Horn, Dr. D. C. Jackson, Dr. Trevor Parry, Dr. H. S. Patterson, Dr. W. H. Steel. Elected *in 1951 for two years: Dr. J. R. Adam, Dr. B. N. Adsett,* Dr. H. W. Anderson, Dr. H. R. Love, Dr. A. D. A. Mayes, Dr. H. M. Saxby, Dr. J. G. Wagner.

ETHICS COMMITTEE.

The following were reelected to the Ethics Committee: Dr. G. W. Macartney, Dr. Val. McDowall, Dr. L. J. J. Nye, Dr. J. J. Power, Dr. R. G. Quinn, Dr. Norman Sherwood, Dr. M. *Graham Sutton.*

ELECTION OF AUDITORS.

Messrs. R. G. Groom and Company were reelected auditors for the ensuing year.

VOTES OF THANKS.

A vote of thanks to the retiring members of the Council and to the Secretary, Mrs. Spooner, and the office staff was moved *by Dr. W. J. Saxton, seconded by Dr. K. B. Fraser,* and carried.

ADJOURNMENT OF MEETING.

The meeting was then adjourned and was resumed in the Great Hall of the Brisbane Boys' Grammar School, Gregory Terrace, Brisbane, *in the presence of His Excellency the* Governor and Lady Lavarack.

DISEASES NOTIFIED IN EACH STATE AND TERRITORY OF AUSTRALIA FOR THE WEEK ENDED NOVEMBER 22, 1952.[1]

Disease.	New South Wales.	Victoria.	Queensland.	South Australia.	Western Australia.	Tasmania.	Northern Territory.	Australian Capital Territory.	Australia.
Acute Rheumatism	7(6)	3(2)	..	..	..	..	..	..	10
Amœbiasis	..	1(1)	1	..	..	..	..	..	2
Ancylostomiasis	..	..	..	..	..	..	..	..	..
Anthrax	..	..	..	..	..	..	..	..	..
Bilharziasis	..	..	..	..	..	..	..	..	..
Brucellosis	..	..	..	..	..	..	..	..	..
Cholera	..	..	..	..	..	..	..	..	..
Chorea (St. Vitus)	..	..	..	..	..	..	..	..	..
Dengue	..	..	..	..	..	..	..	..	..
Diarrhœa (Infantile)	2(2)	..	25(23)	..	..	..	..	..	27
Diphtheria	4(3)	4(4)	5(2)	1(1)	6(3)	..	..	..	20
Dysentery (Bacillary)	..	..	2(2)	..	1(1)	..	..	..	3
Encephalitis	1	..	..	..	..	..	..	..	1
Filariasis	..	..	..	..	..	..	..	..	..
Homologous Serum Jaundice	..	1	..	..	..	..	..	..	1
Hydatid	..	..	..	..	..	1	..	..	1
Infective Hepatitis	..	12(4)	..	..	12(7)	..	..	..	24
Lead Poisoning	..	..	..	..	..	..	..	..	..
Leprosy	..	..	..	..	..	..	..	..	..
Leptospirosis	..	..	..	..	..	..	..	..	..
Malaria	..	..	..	..	..	..	..	..	..
Meningococcal Infection	7(3)	3(2)	1(1)	..	..	2	1	1	15
Ophthalmia	..	..	..	..	..	..	..	..	..
Ornithosis	..	..	..	..	..	..	..	..	..
Paratyphoid	..	..	..	..	..	..	..	..	..
Plague	..	..	..	..	..	..	..	..	..
Poliomyelitis	25(16)	13(8)	5(2)	10(7)	..	14(5)	..	..	67
Puerperal Fever	..	..	1	..	..	..	..	..	1
Rubella	..	153(110)	..	..	4(3)	..	..	1	158
Salmonella Infection	..	..	..	..	..	..	..	..	..
Scarlet Fever	15(5)	30(27)	8(6)	3(2)	3(3)	1(1)	..	..	60
Smallpox	..	..	..	..	..	..	1	..	1
Tetanus	..	..	..	..	..	..	..	..	..
Trachoma	..	..	..	..	..	..	..	..	..
Trichinosis	..	..	..	..	..	..	..	..	..
Tuberculosis	43(32)	15(8)	11(7)	7(4)	8(1)	3(2)	1	..	88
Typhoid Fever	..	..	1	..	..	..	..	..	1
Typhus (Flea-, Mite- and Tick-borne)	..	..	..	..	..	..	..	..	..
Typhus (Louse-borne)	..	..	..	..	..	..	..	..	..
Yellow Fever	..	..	..	..	..	..	..	..	..

[1] Figures in parentheses are those for the metropolitan area.

MEMORIAL ROLL.

The President read the Memorial Roll of members of the Branch, all present standing.

PRESENTATION OF PRIZES.

The following prizes awarded to medical graduates for 1951 were presented by the President:

Memorial Prize of the Queensland Branch of the British Medical Association: Herbert Arthur Copeman, M.B., B.S., University of Queensland.

Harold Plant Memorial Prize: Frederick Schubert, M.B., B.S., University of Queensland.

INDUCTION OF PRESIDENT.

The retiring President, Dr. K. B. Fraser, inducted the incoming President, Dr. T. V. Stubbs Brown.

PRESIDENTIAL ADDRESS.

Dr. T. V. Stubbs Brown delivered his presidential address (see page 897).

Congresses.

FIRST WORLD CONGRESS ON FERTILITY AND STERILITY.

THE first World Congress on Fertility and Sterility will be held on May 25 to 31, 1953, at the Henry Hudson Hotel in New York City. This congress is sponsored by the International Fertility Association with the cooperation of the American Society for the Study of Sterility. Twenty-three scientific sessions are to be held, which will embrace the entire field of fertility and sterility, including sessions dealing with socio-economic factors, psychosomatic aspects and artificial insemination. The sessions will be conducted in English, French and Spanish, with the use of earphones and simultaneous translations, as in the United Nations meetings. In addition to the scientific sessions there will be medical round table discussions, question and answer periods, scientific exhibits and motion pictures. Those interested should write to the chairman of the Local Arrangements Committee, 1160 Fifth Avenue, New York 29, New York, for advance registration.

Obituary.

HAROLD SKARRATT THOMAS.

WE regret to announce the death of Dr. Harold Skarratt Thomas, which occurred on December 1, 1952, at Sydney.

Australian Medical Board Proceedings.

TASMANIA.

THE following have been registered, pursuant to the provisions of the *Medical Act*, 1918, as duly qualified medical practitioners:

Elliot, John Scott, M.B., Ch.B., 1939 (Univ. Edinburgh).

Anderson, Alexander Leslie, M.B., B.S., 1944 (Univ. Melbourne).

Medical Appointments.

Dr. R. B. Knox has been appointed public vaccinator to the Shire of Dundas and City of Hamilton, Victoria.

Dr. T. A. McLean has been appointed public vaccinator to the Shire of Rosedale, Victoria.

Dr. T. B. Winckle has been appointed public vaccinator to the Shire of Chiltern, Victoria.

Dr. J. R. V. Foxton has been appointed chairman of the Mental Deficiency Board and Director of the State Psychological Clinic of Tasmania.

Dr. T. G. H. Hogg has been appointed president of the Physiotherapists' Registration Board of Tasmania.

Dr. I. K. Furler has been appointed honorary medical officer at the Port Augusta Hospital, South Australia.

Nominations and Elections.

THE undermentioned have applied for election as members of the New South Wales Branch of the British Medical Association: McFadden, John Brian, M.B., B.S., 1951 (Univ. Sydney), 54 Harbourne Road, Kingsford; Muir, William McCartney, M.B., B.S., 1952 (Univ. Sydney), 366 Willoughby Road, Naremburn; Morgan, Michael Francis, M.B., B.S., 1952 (Univ. Sydney), Mater Misericordiæ Hospital, Crow's Nest; Mulhearn, Michael Harry Gerald, M.B., B.S., 1941 (Univ. Sydney), Canisius College, Mona Vale Road, Pymble; Brown, Bruce Alexander, M.B., B.S., 1952 (Univ. Sydney), 178 Auburn Road, Auburn.

Diary for the Month.

JAN. 6.—New South Wales Branch, B.M.A.: Council Quarterly.
JAN. 7.—Western Australian Branch, B.M.A.: Council Meeting.
JAN. 8.—South Australian Branch, B.M.A.: Council Meeting.
JAN. 13.—New South Wales Branch, B.M.A.: Executive and Finance Committee.

Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

New South Wales Branch (Medical Secretary, 135 Macquarie Street, Sydney): All contract practice appointments in New South Wales.

Victorian Branch (Honorary Secretary, Medical Society Hall, East Melbourne): Associated Medical Services Limited; all Institutes or Medical Dispensaries; Australian Prudential Association, Proprietary, Limited; Federal Mutual Medical Benefit Society; Mutual National Provident Club; National Provident Association; Hospital or other appointments outside Victoria.

Queensland Branch (Honorary Secretary, B.M.A. House, 225 Wickham Terrace, Brisbane, B17): Brisbane Associated Friendly Societies' Medical Institute; Bundaberg Medical Institute. Members accepting LODGE appointments and those desiring to accept appointments to any COUNTRY HOSPITAL or position outside Australia are advised, in their own interests, to submit a copy of their Agreement to the Council before signing.

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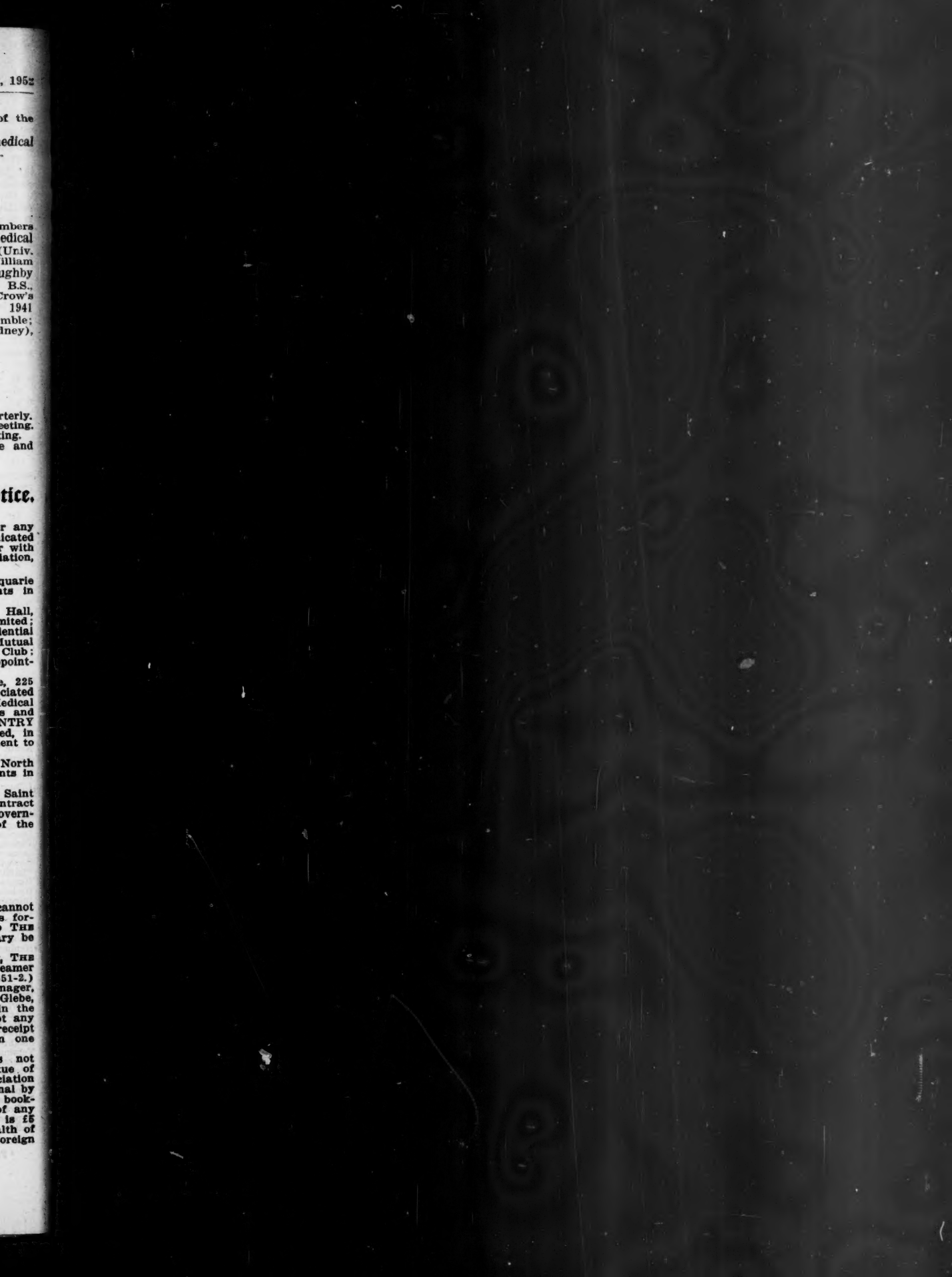
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